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No. _____

In The

Supreme Court of the United States

October Term, 1983

WILLIAM L. LUKHARD, Commissioner of the Virginia Department of Social Services; JAMES B. KENLEY, Commissioner of the Virginia Department of Health; and BRUCE U. KOZLOWSKI, Director of the Virginia Medical Assistance Program,

Petitioners,

v.

EVELYN RANDALL, EMMA MATTHEWS, ARCHIE KYLE MORSE, MINNIE MILLER, WILLIAM R. SMITH, by his next friend JUDY SMITH, POMPEY and RACHEL WINGO, and MAGGIE LAMB,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

1. Was a state's medicaid program, prior to July 1, 1981, preëmpted by federal law from having a transfer-of-assets rule to deter fraud and abuse?

2. When a state has established, by uncontradicted evidence, that the cost of identifying individual class members and of notifying them individually will have more than a *de minimis* effect on the state treasury, may a federal court, consistent with the Eleventh Amendment, order such identification of and notice to each of the class members?

3. May a federal court, consistent with the principle of justiciability, decide the merits of a dispute when the regulation precipitating the question has been voluntarily withdrawn by the state prior to adjudication?

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Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

William L. Lukhard, Commissioner of the Virginia Department of Social Services, James B. Kenley, Commissioner of the Virginia Department of Health, and Bruce U. Kozlowski, Director of the Virginia Medical Assistance Program, petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit, sitting *en banc*, in this matter.[1]

[1] In the United States district court proceeding, the Secretary of the United States Department of Health and Human Services was a defendant. In the proceedings before the court of appeals, the Secre-

I.

OPINIONS BELOW

The initial opinion of the United States Court of Appeals for the Fourth Circuit is reported at 709 F.2d 257 (4th Cir. 1983), and is included in Appendix A at App. 1. The opinion of the court of appeals, sitting *en banc*, has not yet been reported, and it is set forth in Appendix A at App. 36. The order of the court of appeals, granting a rehearing *en banc*, is set forth in Appendix C at App. 91-92. The order of the court of appeals, staying its mandate, is set forth in Appendix C at App. 93-94.

The opinion of the United States District Court for the Western District of Virginia, Charlottesville Division, is reported at 536 F. Supp. 723 (W.D. Va. 1982), and is included in Appendix B at App. 51. A supplemental memorandum opinion and order of the United States District Court, issued on July 22, 1982, was not reported and is also set forth in Appendix B at App. 76.

II.

JURISDICTION

The initial judgment of the court of appeals was entered on June 8, 1983, with one judge dissenting. Petitioners filed, on June 20, 1983, a petition for a rehearing with a suggestion for an *en banc* rehearing, which the court of appeals granted on September 1, 1983. The judgment of the court of appeals, following rehearing *en banc*, was entered on March 12, 1984, with four of the nine judges dissenting. The court of appeals stayed its mandate on April 2, 1984, upon motion of the petitioners, pending application to this

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tary participated as an amicus curiae, supporting Virginia's position. Also, participating as an amicus curiae in support of the plaintiff classes before the court of appeals were the Gray Panthers.

Court for a writ of certiorari. The jurisdiction of this Court to issue a writ of certiorari in this case is grounded upon 28 U.S.C. § 1254(1).

III.

CONSTITUTIONAL, STATUTORY, AND REGULATORY PROVISIONS INVOLVED

The provisions of law involved in this case are too lengthy to be set out verbatim here. They are, however, set out verbatim in Appendix D. Those provisions of law are:

1. The Eleventh Amendment to the Constitution of the United States (App. 95);
2. 42 U.S.C. § 1396a(a)(17) (App. 96);
3. 42 U.S.C. § 1396a(f) (App. 98);
4. 45 CFR § 248.21 (1972) (App. 100);
5. 42 CFR Part 431, subpart E (App. 101);
6. Virginia State Department of Social Services Medicaid Eligibility Manual, § 301.1(D)(3)(App. 112); and
7. Supplement to Attachment 2.6-C to 1980 Virginia State Plan for Medical Assistance (App. 113).

IV.

STATEMENT OF THE CASE

Since the inception of Virginia's medicaid program in 1970, Virginia, like twenty-five to thirty other states,[3] has had a transfer-of-assets rule to deter fraud and abuse by discouraging the purposeful self-impoverishment of persons in order to permit them to qualify for or to remain eligible for medicaid. Prior to July 1, 1981, Virginia's transfer-of-assets rule specified that, if a person transferred property for less than fair market value with the intent

[3] *See* S. Rep. No. 95-111, 95th Cong., 2nd Sess. 24-25 (1978).

to become or to remain eligible for medicaid, he or she would be ineligible for medicaid for a period of one year from the date of transfer. Appendix D at App. 112. As a "209(b) state,"[3] Virginia could have more restrictive eligibility standards than "SSI states", as long as those standards had been in effect on January 1, 1972. The transfer-of-assets rule was one of Virginia's 209(b) eligibility criteria, and it was at all times approved by the Federal Government.

The respondents in a class action[4] challenged the legality of this rule, arguing that the rule violated the concept of "availability" found in title XIX of the Social Security Act and the federal regulations. *See* 42 U.S.C. § 1396a(a)(17) [Appendix D at App. 96]; 45 CFR § 248.21 (1972) [Appendix D at App. 100]. That concept, respondents argued, specified that medicaid eligibility may depend only upon resources which are actually available to an applicant or recipient.[5]

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[3] Pursuant to Pub. L. No. 92-603, § 209(b) [codified as 42 U.S.C. § 1396a(f)], Congress allowed states to use more restrictive eligibility criteria for their medicaid programs rather than the more generous criteria of the Supplemental Security Income Program. This option is popularly referred to as the 209(b) option, and states are either 209(b) states or SSI states for purposes of medicaid eligibility. Appendix D at App. 98.

[4] The district court certified three classes of respondents, but the court of appeals modified those classes to take into account a statute of limitations issue. 709 F.2d at 262-263 n.7. Only one class is involved in this petition:

> All those elderly, blind or disabled persons who (1) applied for medicaid through the Virginia Medical Assistance Program prior to July 1, 1981; (2) were denied medicaid, after any administrative proceedings, on or after April 24, 1978; (3) at the time of their application met all the Medicaid eligibility requirements except the Virginia transfer-of-assets rule; and (4) were denied medicaid because of the application of this rule to property which they transferred before April 24, 1978.

[5] Respondents challenged the rule on other grounds that are not pertinent to this petition. Also, they amended their complaint in July,

In 1980, the Congress enacted the Boren-Long Amendment, Pub. L. No. 96-611 *codified as* 42 U.S.C. § 1396a(j),[6] to clarify that all states, including SSI states, could have medicaid transfer-of-assets rules.[7] *Randall* v. *Lukhard,* No. 82-1773, slip op. at 11 (4th Cir. 1984) (dissenting opinion of Judge Murnaghan) [reprinted in Appendix A at App. 46]. Consequently, Virginia repealed her original rule, and, effective July 1, 1981, she implemented her new rule, which increased the minimum period of ineligibility from one year to two years. Despite its repeal, the district court, on April 16, 1982, held the original rule to be illegal because the "availability" provisions of title XIX and the implementing federal regulations preëmpted Virginia from having such a rule. 536 F.Supp. at 729-731 [Appendix B at App. 56-60].

Further, the district court ordered Virginia to identify all class members, to reinstate all identified members as medicaid recipients if they were currently eligible, and to notify every identified class member by mail that he or she might be eligible for reimbursement for medical bills incurred during the period of disqualification caused by the application of the repealed transfer-of-assets rule. *See* Appendix B at App. 79-80. The district court also ordered Virginia to send notice of its decision to every hospital, nursing home, or other medical or treatment facility in the state which had had, at any time since the original transfer-of-assets rule

1981, to challenge Virginia's new transfer-of-assets rule which took effect July 1, 1981. No question concerning Virginia's new transfer-of-assets rule is at issue in this petition because the court of appeals ultimately concluded that all aspects of the new rule were legal.

[6] 42 U.S.C. § 1396a(j) was repealed in 1982 by section 132 of the Tax Equity and Fiscal Responsibility Act, Pub. L. No. 97-248, and was reenacted as 42 U.S.C. § 1396p(c).

[7] Passage of the Boren-Long Amendment was prompted by decisions of various district courts that concluded that states, particularly 209(b) states, could not have such rules. *E.g., Dokos* v. *Miller,* 517 F. Supp. 1039 (N.D. Ill. 1981). Those decisions, however, preceded *Schweiker* v. *Gray Panthers,* 453 U.S. 34 (1981).

was enacted, a medicaid provider agreement with Virginia. *Id.* at App. 80.

The uncontradicted evidence of record established that Virginia would have to review 99,962 cases which were active as of March, 1982, as well as 331,304 closed cases in an attempt to identify class members. *See* Appendix D at App. 114-115. (Affidavit of Mr. I. Guy Lusk). That effort would require 15,064 man hours at a cost of $164,510.00. *Id.* at App. 115. In addition, Virginia has no regular mailing to the class members which would minimize that expense, as was the case in *Quern* v. *Jordan,* 440 U.S. 332 (1979). Appendix D at App. 117. (Affidavit of Ms. Ann E. Cook). Such a mailing would cost thousands of dollars. *Id.*

Further, due to quarterly changes in medicaid eligibility criteria, eligibility criteria for each person who responded to the notice would have to be reconstructed for each quarter to determine whether each would have been eligible and whether each would have remained eligible during the period of time for which each was disqualified due to the transfer-of-assets rule. *Id.* at App. 118. The expense of reconstructing these eligibility criteria would be "significant." *Id.* at App. 119. Once those criteria were reconstructed, it would cost Virginia $19.65 to process each application to determine eligibility. Appendix D at App. 115.

Furthermore, assuming that only one thousand people responded to the notice, it would cost Virginia $1,500,000.00 to prepare and research these claims for payment. Appendix D at App. 120. In other words, excluding the costs that would be associated with the mailing of notice and with the determinations of eligibility, Virginia would then incur an additional expense of determining whether claims are payable. This is because Virginia cannot avail herself of her normal computer processing of claims for payment. Claims presented by class members "must be edited, priced and

forced through the claims payments system," and the service would have to be "manually priced to reflect the Program's fee schedule in effect on the date of the claim for the service in question." *Id.* at App. 119.

Petitioners appealed the district court's decision on the grounds: (1) that Virginia was not preëmpted by federal law prior to July 1, 1981, from having a transfer-of-assets rule to deter fraud and abuse; (2) that the district court's order to identify and to give individual, mailed notice to class members, the consequence of which is to compel Virginia to reconstruct medicaid eligibility criteria for each of them, and to give institutional providers notice violated the Eleventh Amendment because it would engender more than a *de minimis* effect on the state treasury; and (3) that a challenge to the repealed rule did not constitute a justiciable case or controversy.

The court of appeals affirmed the decision of the district court on the statutory issue, initially in a two to one panel decision and ultimately in a five to four *en banc* decision. With respect to the Eleventh Amendment issue, the court of appeals found that Virginia had not demonstrated anything more than a *de minimis* effect, notwithstanding her uncontradicted evidence on the point. *See* Appendix D at App. 114-120. (Affidavits of Mr. I. Guy Lusk and of Ms. Ann E. Cook). With respect to the justiciability issue, the court of appeals failed to address it.

V.

JURISDICTION OF THE UNITED STATES DISTRICT COURT

The United States District Court for the Western District of Virginia, Charlottesville Division, assumed jurisdiction of this matter under 28 U.S.C. § 1331 and 28 U.S.C. § 1343(3). 536 F.Supp. at 725 (App. 51).

VI.

REASONS FOR GRANTING THE WRIT OF CERTIORARI

A.

Federal Law Did Permit Virginia To Have A Transfer-Of-Assets Rule Prior To July 1, 1981

The circuits are in conflict as to the statutory issue of whether a 209(b) state could have a transfer-of-assets rule prior to 1981. The Court of Appeals for the Seventh Circuit has ruled that Indiana, also a 209(b) state, had a valid pre-1981 transfer-of-assets rule which it could continue to apply. *Synesael* v. *Ling*, 691 F.2d 1213 (7th Cir. 1982), *reh. denied* January 20, 1983, *cert. denied* ____ U.S. ____, 103 S.Ct. 3092, 77 L.Ed.2d 1352 (1983).[8] That decision is contrary to the decision here.

This fact is indisputable notwithstanding the portion of the Fourth Circuit's decision which attempts to distinguish *Synesael* v. *Ling*. *See Randall* v. *Lukhard*, 709 F.2d at 265. (Appendix A at App. 11) ["We do not think that *Synesael* requires the Commonwealth's suggested result."] However, the dissent in this case and the dissent in *Synesael* v. *Ling* clearly indicate that both courts of appeal heard, considered, and dealt with the same statutory issue and arguments concerning the "availability" of resources. *Compare Randall* v. *Lukhard*, 709 F.2d at 272 and 274 (Appendix A at App. 23 and 29) [Judge Russell's dissent in which three other judges joined after the rehearing *en banc*] *with Synesael* v.

[8] Indiana's transfer-of-assets rule, which had been in effect on January 1, 1972, allowed Indiana to disqualify applicants or recipients for a transfer which had occurred anytime within the previous five years. The Seventh Circuit concluded that, as a 209(b) state, Indiana was not required to use the two year "reachback" provision of the Boren-Long Amendment, but could continue to rely upon its five year provision.

Ling, 691 F.2d at 1217-1220. In terms of result, the Court of Appeals for the Seventh Circuit permitted Indiana to have a transfer-of-assets rule prior to 1981 to deter fraud and abuse while the Court of Appeals for the Fourth Circuit forbade Virginia to have such a rule.

This latter result reached by the Fourth Circuit is inconsistent with the well-established principle that a state may promulgate additional eligibility criteria in social-welfare programs. In *New York State Department of Social Services* v. *Dublino,* 413 U.S. 405 (1973), this Court held that additional programs and procedures are not necessarily invalid, any more than other supplementary regulations promulgated within the legitimate sphere of state administration. *Id.* at 423. In addition, this Court's ruling in *Lavine* v. *Milne,* 424 U.S. 577 (1976), indicates that states may legitimately interpose additional rules in social-welfare programs which discourage fraud and abuse. This Court has made clear that applicants for public aid must be free of an "impermissible benefit-seeking motive." *Id.* at 585. Also, this Court summarily affirmed *Buckner* v. *Maher,* 424 F. Supp 366, 373 (D. Conn. 1976), which spoke favorably of transfer-of-assets rules to deter fraud and abuse. *Maher* v. *Buckner,* 434 U.S. 898 (1977).[9] Accordingly, the decision of the Court of Appeals for the Fourth Circuit is contrary to this Court's prior decisions.

Lastly, this Court has held that the concept of "availability" in title XIX of the Social Security Act, 42 U.S.C. § 1396a(a)(17), does not mean that resources need to be actually in hand. *Schweiker* v. *Gray Panthers,* 453 U.S. 34,

[9] In *Buckner* v. *Maher,* the district court held Connecticut's transfer-of-assets rule to be illegal because it imposed an "unlimited" burden of proof on an applicant, but the court expressly noted that its analysis did not take into account any fraud or abuse justification for the rule because the state did not defend on those grounds. 424 F. Supp. at 373.

44 (1981). Further, this Court has held that the courts should be particularly deferential to the federal secretary's interpretation of this provision of federal law. *Id.* at 48. In that regard, the Secretary of the United States Department of Health and Human Services has consistently supported Virginia's position on this statutory issue throughout the litigation. As succinctly stated by Judge Russell in his dissent:

> To summarize: (1) The Secretary, to whom the authority to interpret this statute was delegated under what the Supreme Court has characterized as an "exceptionally broad authority," has consistently and does now assert that "§ 209(b)" states had absolutely valid authority prior to the effective date of Boren-Long to have their own transfer of assets rule in their plan of Medicaid assistance; (2) Congress was aware of this construction of the statute by the Secretary and implicitly approved of it as a proper application of what it intended by the 1972 amendment; (3) And, as I read *Gray Panthers* [i.e., *Schweiker* v. *Gray Panthers*] and *Hogan*, [i.e., *Schweiker* v. *Hogan*, 457 U.S. 569 (1982)], both, in my opinion, read the authority of the Secretary and the effect of the 1972 amendment as sustaining the right of "§ 209(b)" states, prior to the Boren-Long Amendment, to enforce a transfer of assets rule. 709 F.2d at 273 (App. 25).

Thus, the decision of the court of appeals in this case is especially contrary to this Court's decision in *Schweiker* v. *Gray Panthers*. Therefore, petitioners submit that this Court ought either to reverse the judgment of the court of appeals summarily or to accept review of this issue to correct the lower federal court's error.

B.

The Eleventh Amendment Precludes The Federal Courts From Requiring The States To Identify And Notify Class Members And Providers Of Medicaid Services When That Requirement Will Engender More Than A *De Minimis* Effect On The State Treasury

This case is illustrative of the need for this Court to complete that which was started in *Edelman* v. *Jordan,* 415 U.S. 651 (1974), and continued in *Quern* v. *Jordan,* 440 U.S. 332 (1979). The federal courts, states like Virginia, and litigants, such as the respondents in this case, expend inordinate amounts of time and effort, wrestling with whether a state can be compelled to identify class members, to notify them individually by mail, and, in this particular case, to reconstruct past, non-static eligibility requirements for the prior five years and apply them to individual members of the class when that will compel a state to expend significant amounts of money, manpower, and material to comply with the court's order.

As stated earlier, the uncontradicted evidence of record established that Virginia would have to review 99,962 cases which were active as of March, 1982, as well as 331,304 closed cases in an attempt to identify class members. *See* Appendix D at App. 114-115. (Affidavit of Mr. I. Guy Lusk). That effort alone would require 15,064 man hours at a cost of $164,510.00. *Id.* at App. 115. In addition, Virginia has no regular mailing to the class members which would minimize that expense, as was the case in *Quern* v. *Jordan.* Appendix D at App. 117. (Affidavit of Ms. Ann E. Cook). Such a mailing would cost thousands of dollars. *Id.*

Further, due to quarterly changes in eligibility criteria, eligibility criteria for each person who responded to the notice would have to be reconstructed to determine whether

each would have been eligible and whether each would have remained eligible during the period of time for which each was disqualified due to the transfer-of-assets rule. *Id.* at App. 118. The expense of reconstructing these eligibility criteria would be "significant." *Id.* at App. 119. Once the criteria were reconstructed, it would cost Virginia $19.65 to process each application to establish whether the applicant would have been eligible. Appendix D at App. 115.

Assuming that only one thousand people responded to the notice, it would cost Virginia $1,500,000.00 to prepare and research these claims for payment. *Id.* at App. 120. In other words, excluding the costs that would be associated with the mailing of notice and with the determinations of eligibility, Virginia would then incur an additional expense of determining whether claims are payable. This is because Virginia cannot avail herself of normal computer processing of claims for payments. Claims presented by class members "must be edited, priced and forced through the claims payment system," and the service would have to be "manually priced to reflect the Program's fee schedule in effect on the date of the claim for the service in question." Appendix D at App. 119.

State resources are limited, and it is not feasible to absorb such fiscal consequences or simply to appropriate additional monies. Indeed, Virginia would be penalized if it appropriated more funds to carry out this mandate because Congress has placed a cap on total medicaid expenditures in order to bring the program under control. 42 U.S.C. § 1396b(s)(1)(A). One of the consequences of the Congress' action in this regard was that the Virginia General Assembly in its 1982 session enacted a wide range of cost-containment measures to avoid federal fiscal penalties and to achieve fiscal control over the program. *See* 1982 Acts of

Assembly, Ch. 684, Item 418. Therefore, it would be better to use limited state resources to deliver services to recipients who are currently in need. If compelled to comply with the identification and notice requirements of the district court's order, Virginia's only other alternative is to reduce the current level of services or to eliminate groups of eligible persons to stay within current appropriations.

Petitioners note that the court of appeals avoided deciding the question of whether the judicially required identification and notice of class members is unconstitutional by opining that Virginia did not demonstrate that the district court's order would engender more than a *de minimis* effect on the state treasury. *Randall* v. *Lukhard,* 709 F.2d at 270 (Appendix A at App. 20) [original panel decision]. With all due respect to the majority of the court of appeals, it is an abuse of discretion to ignore the uncontradicted evidence of record that the costs associated with the identification and notice would be substantial. *See United States* v. *General Motors Corp.,* 384 U.S. 127, 141 n. 16 (1966) [wherein this Court commented that a question of fact is not presented where the facts are undisputed; that conclusions based upon such facts are not shielded by the "clearly erroneous" test, particularly in a "paper case" where there was no live testimony as was the situation in *Randall* v. *Lukhard*]; *accord Hicks* v. *United States,* 368 F.2d 626, 630-631 (4th Cir. 1966). ["It has often been held that where the trial court's conclusions are based on undisputed facts, they are not entitled to the finality customarily accorded. . . ."]; *see also* Appendix D at App. 114-120. [Affidavits of Mr. I. Guy Lusk and Ms. Ann E. Cook].

A demonstration of this error on the part of the court of appeals is that court's observation that costs of identifying the class members should not be considered in determining

whether there were more than a *de minimis* effect because the district court's order already required Virginia to identify the class members. 709 F.2d at 270 (App. 20). Such reasoning is specious because the only reason Virginia was required to identify the class members was to enable her to satisfy the notice requirements of the district court's order. The costs of both, therefore, are inextricably combined, and both must be considered to determine whether Virginia demonstrated more than a *de minimis* effect.

The fact that the court of appeals felt obliged to indulge in such erroneous rationalization is, Virginia submits, proof that Virginia did make the necessary showing. If she did not, then no state will ever be able to make such a showing because a state can do no more than Virginia did. Thus, what constitutes more than a *de minimis* impact upon a state treasury is another important facet of the larger question and is deserving of this Court's consideration and decision.[10]

In summary, the constitutional issue of the Eleventh

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[10] Other aspects of the Eleventh Amendment issue are present in this case. For example, Virginia contended throughout the litigation that identification of and notice to class members was futile because no state mechanism existed which could award damages. The respondents argued vigorously that class members could avail themselves of the federal fair hearing regulations, 42 CFR Part 431, subpart E, to obtain those damages. Appendix D at App. 101-111. However, those regulations, as implemented in Virginia, require an applicant or recipient to request a hearing within thirty days from the date of the adverse decision denying benefits. That thirty day period has run for each and every class member in this case. The court of appeals mistakenly assumed that Virginia would waive the thirty day requirement for good cause shown, *see* 709 F.2d at 269 (App. 19), but that is not possible as a matter of state law.

Secondly, the court of appeals *sua sponte*, without any prior briefing from the parties, identified *one* Virginia statute, § 8.01-255 of the Code of Virginia, which it thought available to provide a state judicial remedy. *Id.* at 270 (App. 19). However, the court of appeals failed to consider other related state statutes, *e.g.*, § 2.1-223.1 and § 8.01-192 of the Code of Virginia, and, more importantly, the opinions of the Supreme Court of Virginia which restrict those state statutes to contractual disputes. *E.g., Stuart, Gov.* v. *Smith-Courtney*

Amendment repeats itself in every social-welfare case where a plaintiff class has been partially successful. This Court has repeatedly held that the Eleventh Amendment is not to be lightly regarded. *E.g., Alabama* v. *Pugh,* 438 U.S. 781 (1978); *Florida Department of Health and Rehabilitative Services* v. *Florida Nursing Home Ass'n.,* 450 U.S. 147, *reh. denied* 451 U.S. 933 (1981). Virginia would respectfully submit, therefore, that the time has come to decide this important issue, thereby providing a final answer to a troublesome problem.

C.

Litigation Over Repealed Regulations Offends The Constitutional Concept Of Justiciability

Congress' enactment, in 1980, of the Boren-Long Amendment had a profound effect upon this litigation. As a result of that federal legislation, Virginia voluntarily repealed its transfer-of-assets rule, effective July 1, 1981.[11] Having done so, Virginia submits that the district court erred when, almost a year later, it held that the repealed rule had been illegal during the years it was operative. Consequently, as it stands now under this case, federal courts are in the business of deciding, perhaps interesting but nonetheless moot, questions concerning rules and regulations that have been repealed.

The naked reality of that concept is disturbing when one considers its ramifications. Under this approach to justiciability, a class of plaintiffs could challenge any repealed regulation, relying upon new legal developments which were

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Co., 123 Va. 231, 232-233 (1918); *Davis* v. *Marr,* 200 Va. 479, 485-486 (1959). Welfare benefits are, however, non-contractual in nature. *Weinberger* v. *Salfi,* 422 U.S. 749, 771-772 (1975). Consequently, there is no state mechanism for the award of damages.

[11] Under the holding of *Synesael* v. *Ling,* Virginia was not required to abandon its original transfer-of-assets rule because she was a 209(b) state.

nonexistent during the life of the regulation. This is a significant expansion of the federal courts' jurisdiction.

This Court held in *Beltran* v. *Myers*, 451 U.S. 625 (1981), that the court of appeals in that case should reconsider its ruling on California's transfer-of-assets rule because passage of the Boren-Long Amendment "raises the question whether it is appropriate for the Court to decide the merits of the underlying dispute as considered by the court of appeals." *Id.* at 627. However, both the district court and the court of appeals in the instant case disregarded this Court's direction in *Beltran* v. *Myers*. They decided, *sub silentio*, that litigation over a repealed regulation is a "case and controversy" and is, therefore, justiciable. Such a holding is contrary to this Court's opinions. *E.g.*, *Poe* v. *Ullman*, 367 U.S. 497 (1961); *Flast* v. *Cohen*, 392 U.S. 83 (1968).

VII.

CONCLUSION

With respect to the statutory question concerning the meaning of "availability," only five members of the nine member court of appeals voted in favor of the judgment below. The four dissenters agreed that the judgment of the court of appeals was inconsistent with the result reached by the Seventh Circuit in *Synesael* v. *Ling*. More importantly, the decision of the Fourth Circuit is contrary to the decisions of this Court in *Schweiker* v. *Gray Panthers*, *Schweiker* v. *Hogan*, *New York State Department of Social Services* v. *Dublino*, and *Lavine* v. *Milne*. Thus, petitioners submit they have clearly demonstrated reasons under Rule 17.1a and 17.1c of the Rules of the Supreme Court to justify granting the writ of certiorari.

Furthermore, the constitutional issue framed under the Eleventh Amendment is significant. This Court has held

that identification of and notice to class members which engenders only a *de minimis* effect upon the state treasury is not unconstitutional. Now is the time to decide the converse of that: may a federal court order identification of and notice to class members when the expense is not *de minimus?* Now is also the time to decide what a *de minimis* expense is. Thus, on this issue, petitioners submit they have demonstrated a basis under Rule 17.1c of the Rules of the Supreme Court to justify granting the writ of certiorari.

Likewise, is it the function of federal courts to litigate the legality of repealed regulations? The potential consequences of answering that question in the affirmative are staggering, and, Virginia submits, inconsistent with the constitutional principles of justiciability. Therefore, petitioners submit they have also demonstrated reasons for granting the writ of certiorari specified in Rule 17.1c of the Rules of the Supreme Court.

Consequently, the petitioners urge this Court either to reverse summarily the judgment of the court of appeals or to grant the writ of certiorari.

Respectfully submitted,
WILLIAM E. LUKHARD, *et al.*

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APPENDIX A

App. 1

RANDALL v. LUKHARD

Cite as 709 F.2d 257 (1983)

Evelyn RANDALL, Emma Matthews, Archie Morse, Minnie Miller, by her next friend, Viola Liskey, on behalf of themselves and all others similarly situated, and Maggie Lamb, Pompey Wingo, Rachel Wingo and William E. Smith, Appellees,

v.

William L. LUKHARD. Comm. of the Commonwealth of VA Dept. of Welfare, Dr. James B. Kenley, Comm. of Health for the Commonwealth of VA, and Dr. Freeman C. Hays, Dir. of VA Medical Assistant Program, Appellants.

and

Richard Schweiker, Sec. H & H Services, Amicus Curiae.

Evelyn RANDALL, Emma Matthews, Archie Morse, Minnie Miller, by her next friend, Viola Liskey, on behalf of themselves and all others similarly situated, and Maggie Lamb, Pompey Wingo, Rachel Wingo and William E. Smith, Appellants,

v.

William L. LUKHARD, Comm. of the Commonwealth of VA Dept. of Welfare, Dr. James B. Kenley, Comm. of Health for the Commonwealth of VA and Dr. Freeman C. Hays, Dir. of VA Medical Assistance Program, Appellees,

and

Richard Schweiker, Sec. H & H Services, Defendant.

Nos. 82-1773, 82-1774.

United States Court of Appeals, Fourth Circuit.

Argued Feb. 7, 1983.

Decided June 8, 1983.

Before WINTER, Chief Judge, RUSSELL, Circuit Judge, and FAIRCHILD.* Senior Circuit Judge.

HARRISON L. WINTER, Chief Judge:

Before us are challenges to the Virginia Medicaid program's former and current "transfer of assets" eligibility rules, as applied to Medicaid applicants and recipients from April 24, 1978 through the present. These rules direct that an individual who transfers property for less than its fair market value, in order to become or remain eligible for Medicaid, is to be denied such assistance for a specified period of time.

Summarizing our conclusions, we agree with the district court that the former rule violated federal law and affirm, among others, that part of the district court's order, 536 F.Supp. 723, requiring that persons denied assistance under the former rule be given notice of this judgment, although we require that the content of the notice be modified. We reverse in part the district court's determination that the new rule is in all respects lawful; we think that it imposes an excessive burden of proof on persons attempting to demonstrate that their transfers were made for permissible reasons. We affirm the validity of the remainder of the new rule. We also reverse the district court's ruling that the new rule may not lawfully be applied to persons whose initial

applications for assistance were filed prior to July 1, 1981. We think that the new rule may be applied to initial eligibility determinations made on or after July 1, 1981, even if the application was filed prior to that date, and to any eligibility redetermination occurring on or after July 1, 1981. We therefore reverse the district court's order granting relief to these individuals.

I.

The history of the Medicaid program and its provisions under which the present case arose were reviewed by the Supreme Court in *Schweiker* v. *Gray Panthers,* 453 U.S. 34, 36-39, 101 S.Ct. 2633, 2636-2637, 69 L.Ed.2d 460 (1981). As noted there, the Medicaid program was established in 1965 to "provid[e] federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Id.* at 36, 101 S.Ct. at 2636, quoting *Harris* v. *McRae,* 448 U.S. 297, 301, 100 S.Ct. 2671, 2680, 65 L.Ed.2d 784 (1980). Each participating state was required to have a plan for determining the eligibility of individuals seeking medical assistance. 42 U.S.C. § 1396a(a). The criteria for eligibility included a maximum level of income and resources. Relevant to that determination, the state plan was required to "include reasonable standards. . . which. . . provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient." *Id.* § 1396a(a)(17). The Secretary's regulation in effect on January 1, 1972 provided that the state plan must "[p]rovide that only such income and resources as are *actually available* will be considered." 45 C.F.R. § 248.21(a)(2)(i) (1972) (emphasis added).[1]

As Medicaid was originally enacted, participating states were required to provide medical assistance only to those

persons eligible to receive categorical assistance under one of four welfare programs established elsewhere in the Social Security Act. 42 U.S.C. § 1396a(a)(10) (1970). Effective January 1, 1974, however, Congress replaced three of the four categorical assistance programs with the Supplementary Security Income ("SSI") program. 42 U.S.C. § 1381 *et seq.* Under the new program, the federal government assumed the responsibility for defining standards of eligibility for categorical (now SSI) assistance theretofore borne by the states. *Id.* § 1382. The new federal standards expanded the class of individuals eligible to receive such assistance, and hence threatened to expand Medicaid eligibility, which under the Social Security Act was linked coterminously with SSI eligibility. *Id.* § 1396(a)(10). Congress feared that many states would withdraw entirely from the Medicaid program rather than expand their coverage and resultant obligations. Therefore, "in order not to impose a substantial burden on these states," S.Rep. No. 93-553, 93d Cong., 1st Sess. 56 (1973), or discourage them from participating, Congress offered the states the "§ 209(b) option." Under this option, a state may choose to provide medical assistance only to those individuals who would have been eligible to receive assistance under the state Medicaid plan in effect on January 1, 1972. 42 U.S.C. § 1396a(f).[2] Virginia elected to exercise the § 209(b) option, and therefore at all relevant times has limited medical assistance to those individuals who would have been eligible under the Virginia plan in effect on January 1, 1972.

Virginia had its former transfer of assets rule in effect on January 1, 1972. As of that date, the rule provided that a Medicaid applicant or recipient would be ineligible for benefits for a period of one year if he had transferred property for less than its fair market value within one year of the date of

application or while receiving benefits,[3] and such transfer was made in order to become or remain eligible for Medicaid.[4]

Plaintiffs filed the present action on April 24, 1980, seeking, under 42 U.S.C. § 1983, a declaration that the Virginia rule was inconsistent with the Social Security Act, an injunction against further enforcement of the rule, and the reinstatement to eligibility of persons denied assistance because of the rule.

In December of 1980, however, the Boren-Long Amendment to the Social Security Act was signed into law. Pub.L. No. 96-611, § 5, 94 Stat. 3567 (1980), codified at 42 U.S.C. §§ 1382b(c) and 1396a(j).[5] The Amendment authorized state Medicaid plans to employ a transfer of assets rule providing for the inclusion in an applicant's resources of any property transferred for less than its full value within the preceding twenty-four months in order for the transferor to become or remain eligible for assistance. 42 U.S.C. §§ 1382b(c)(1), 1396a(j)(1). The amendment also authorized § 209(b) states to provide for a specified period of ineligibility in excess of twenty-four months where the amount of uncompensated value exceeded $12,000, rather than providing for inclusion in the person's resources of the uncompensated amount. *Id.* § 1396a(j)(2). In § 209(b) states, however, the state plans containing a transfer of assets disqualification were required to specify a procedure that otherwise is "not more restrictive" than that specified for the SSI transfer of assets rule in 42 U.S.C. § 1382b(c). *See id.* § 1396a(j)(1). In particular, that procedure requires the transferor to furnish "convincing evidence" that the transaction was exclusively for a purpose other than establishing eligibility for assistance. *Id.* § 1382b(c)(2).

Virginia amended its rule, effective July 1, 1981, in order

to conform to Boren-Long.[6] Under the new Virginia rule, an applicant is ineligible for a specified period of time if he has transferred property for less than fair market value within the preceding two years, or, for a recipient, within two years of the discovery of that transfer. The period of ineligibility is specified as two years from the date of the transfer, plus an additional two months for every $1,000 or part thereof in uncompensated value in excess of $12,000. The new rule provides that the burden is on the client to demonstrate, by objective evidence and not merely a subjective statement of intent or ignorance, that the transfer was not made in an effort to qualify for Medicaid. The client must "provide evidence that other resources were available, at the time of transfer, to meet current and expected needs of that client, including costs of nursing home care."

Plaintiffs then amended their complaint by adding two challenges to the new rule. First, they sought an injunction against its application to persons filing their initial Medicaid applications on or after July 1, 1981, the effective date of Boren-Long. Second, they sought an injunction against application of the new rule to persons whose initial applications had been filed but not yet been acted upon before that date or whose eligibility was being redetermined on or after that date.

The district court certified three plaintiff classes: (1) persons who applied for Medicaid from April 24, 1978[7] through June 30, 1981 and were denied assistance because of transfers made before July 1, 1979 [i.e., persons to whom the former rule had been applied]; (2) persons who applied from April 24, 1978 through June 30, 1981 and were denied assistance because of transfers made on or after July 1, 1979 [i.e., persons who initially applied under the former rule but

to whom the new rule had been applied[8]]; and (3) persons who applied on or after July 1, 1981 and were denied assistance because of transfers made on or after July 1, 1979 [i.e., persons who applied under, and were denied assistance because of, the new rule].

The district court decided that the former rule, as it had been applied to the first class, had violated the Supremacy Clause by conflicting with the Social Security Act and HEW regulations requiring states to include only those resources "actually available" to the applicants and recipients. The court also decided that the new rule, although lawful as applied to the third class (i.e., persons who initially applied for Medicaid on or after July 1, 1981), could not be applied at all to any person whose initial application had been filed prior to July 1, 1981 (i.e., the second class). The district court ordered the state to cease such application of the new rule, to restore to eligibility all members of the first and second classes who now meet all other applicable eligibility criteria, and to send notices to all members of the first and second classes that their federal rights had been violated and that they might seek reimbursement for past expenses through state proceedings.[9]

The Commonwealth appeals from these orders, and plaintiffs appeal from the judgment that the new rule is valid as applied to the third class.

II.

[1] We consider first the validity of Virginia's former transfer of assets rule. Under 42 U.S.C. § 1396a(a)(17), the state plan was required to take into account only such resources as were, in accordance with the Secretary's standards, "available" to the client. On January 1, 1972, the Secretary's standards required that such resources be "ac-

tually available." We agree with the district court that Virginia's former rule violated this plain language by including resources no longer "actually available" to the applicant or recipient.[10] It is apparent that resources that were previously irrevocably transferred to another person, regardless of the amount of compensation received, simply are no longer actually available. Moreover, the legislative history of the Act makes clear that Congress was concerned that only those resources "actually available" be counted. *See Gray Panthers*, 453 U.S. at 47 n. 17, 101 S.Ct. at 2642 n. 17.

The Commonwealth argues that, despite this plan language, its transfer of assets rule did not violate the Act's availability requirement. Specifically, Virginia urges that *Gray Panthers* held that "available" resources need not be "in hand." It is true that *Gray Panthers* did uphold the Secretary's regulations permitting the income of one spouse to be "deemed" as part of the income "available" to the other. But the Court's rationale in *Gray Panthers* was that, because of the extraordinary complexity of the Social Security Act, unusually great deference is to be accorded to the Secretary's regulations giving content and meaning to the Act and its terms. Indeed, the regulations deferred to in *Gray Panthers* were interpreting the precise part of 42 U.S.C. § 1396a(a)(17) at issue here. Moreover, the Court noted that "deeming" of spousal income was recognized in the Act and in the legislative history as being consistent with the requirement that only "available" or "actually available" income be counted.[11] There is no similar indication suggesting that Congress saw transfer of assets rules as being consistent with the availability requirement. Therefore, we think that *Gray Panthers* actually supports the argument that we must give to the Secretary's regulation its plain meaning.

The Commonwealth also argues that the "actually avail-

able" regulation applies only to "financial eligibility" standards within state Medicaid plans, and not to fraud-deterring standards. We specifically rejected this argument in *Fabula* v. *Buck*, 598 F.2d 869, 873-74 (4 Cir.1979), where Maryland claimed that its transfer of assets rule was a collateral restriction to eliminate fraud, rather than a substantive eligibility requirement. The same reasoning employed there applies here.[12]

We hold, therefore, that on January 1, 1972, Virginia's transfer of assets rule conflicted with federal law and was invalid. As a § 209(b) state, Virginia was authorized, from January 1, 1974 onward, to use eligibility standards more restrictive than SSI only if they were contained in its plan in effect on January 1, 1972. 42 U.S.C. § 1396a(f). We interpret that limitation to mean that a § 209(b) state may use only those restrictions that were *lawfully and validly* part of its plan in effect on January 1, 1972. The Fifth Circuilt, in reaching this conclusion, said in *Norman* v. *St. Clair*, 610 F.2d 1228, 1235 (5 Cir.1980), *cert. denied*, 453 U.S. 922, 101 S.Ct. 3159, 69 L.Ed.2d 1005 (1981):

> Although § 209(b) allows states to use standards more restrictive than those under the SSI program, the provision can not be viewed as an all-purpose "grandfathering" clause which effectively legitimizes any and every provision appearing in a state plan in 1972. We find no indication that in passing § 209(b) Congress intended to authorize otherwise improper procedures. In other words, if, in January, 1972, the state's deeming procedure was impermissible under 42 U.S.C. § 1396a (a)(17), it cannot now be made acceptable simply because of § 209(b).

We agree that the purpose of the § 209(b) option was simply to permit the states to assist only those persons whom the states were required to assist prior to the expansion of

categorical assistance. Because the "actually available" requirement existed prior to that expansion, we reject any suggestion that § 209(b) authorized the states to continue employing rules that theretofore had conflicted with that requirement.

Because Virginia's transfer of assets rule was not validly in effect as part of its plan on January 1, 1972, it was invalid, as of January 1, 1974, under 42 U.S.C. § 1396a(f), the § 209(b) option. It remained invalid under § 1396a(f) until such time as Congress, by its passage of the Boren-Long Amendment, authorized the states to employ transfer of assets rules notwithstanding § 1396a(f)'s requirement that all rules must have been validly in effect on January 1, 1972.[13] Therefore, the former Virginia rule was invalid at all relevant times: from April 24, 1978, the earliest date for which the statute of limitations for challenging the rule had not expired, until July 1, 1981, the date on which the Boren-Long Amendment authorized Virginia to employ a transfer of assets rule.

The Commonwealth contends that this analysis conflicts with that of the Seventh Circuit in *Synesael* v. *Ling,* 691 F.2d 1213 (7 Cir.1982). There, Indiana's transfer of assets rule in 1972 had provided that if an applicant transferred property for less than its fair market value within the five years preceding his application for Medicaid, he would be disqualified for a period of two years, or for a period of five years if the amount of uncompensated value exceeded $12,000. The same rule continued in effect after July 1, 1981, the effective date of the Boren-Long Amendment, and plaintiffs argued that continued enforcement of the Indiana rule would violate Boren-Long, 42 U.S.C. § 1396a(j)(1), by being procedurally "more restrictive" than the SSI transfer of assets rule in 42 U.S.C. § 1382b(c). The panel ma-

jority, however, found nothing in the legislative history to indicate that Congress, in passing the Boren-Long Amendment, had intended to expand Medicaid eligibility in any state; rather, just the opposite. Therefore, so as to uphold continued use of Indiana's rule, the majority read § 1396a-(j)(1) as imposing the new transfer of assets rule only where the client would otherwise have been eligible under the state plan in effect—i.e., only in states that did not already have their own transfer of assets rule in effect.

We do not think that *Synesael* requires the Commonwealth's suggested result. The challenge there was only whether the adoption of Boren-Long prohibited Indiana's continued use of its rule; we deal here with the Virginia rule's validity *prior* to the effective date of Boren-Long. While we recognize that a necessary premise of the *Synesael* majority's decision that the Indiana rule is valid after Boren-Long is an assumption that it also was valid prior to Boren-Long, the majority simply accepted the agreement of the parties that Indiana's rule was valid in 1972. 691 F.2d at 1214-15. The majority did not have argued to it, nor did it analyze, the issue that we think critical: were transfer of assets rules in § 209(b) states valid on January 1, 1972? Because we do not think that an unanalyzed assumption is compelling authority, we decline to follow it when our analysis impels us to a different conclusion.[14]

We thus affirm the district court's judgment that the former Virginia transfer of assets rule was invalid as it was applied to the first class.[15]

III.

We turn next to the question of whether Virginia's new transfer of assets rule may, consistent with federal law, be applied to persons whose initial applications for Medicaid

were filed on or after July 1, 1981, the effective date of both the Boren-Long Amendment and the new rule. The district court upheld the new rule in all respects. Plaintiffs appeal only from the district court's judgment that the new rule's provisions defining the burden of proof on clients to demonstrate that their transfers were not made for unlawful purposes conform to the burden of proof authorized by the Boren-Long Amendment.

Under the Amendment, 42 U.S.C. § 1396a(j)(1), state transfer of assets rules must employ a procedure which is "not more restrictive" than that prescribed for the SSI transfer of assets rule in § 1382b(c).[16] That section states that any transfer of an asset for less than its fair market value within the preceding two years "shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this chapter unless [the] individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for some other purpose." *Id.* § 1382b(c)(2).

The new Virginia rule provides that, in order to meet this burden, the client must furnish objective evidence of a lawful purpose; a subjective statement of intent or of ignorance of the rule is not sufficient. Further, the client must provide evidence to establish that other resources were available to him, at the time of the transfer, to cover present and expected future medical costs.[17]

In considering the equivalence of these rules, the district court took notice of two federal interpretations of § 1382b-(c)'s "convincing evidence" burden. First, the HHS regulations, 46 Fed.Reg. 51,779 (1981), state that "[c]onvincing evidence may be pertinent documentary evidence (for example, legal documents, realtor agreements, relevant correspondence, etc.)." Second, the SSI claims manual requires

that the agency investigator take the claimant's statement as to his purpose for making the transfer, attempts to dispose of the asset at fair market value, reasons for accepting less, means or plans for supporting himself after the transfer, relationship to the transferee, and belief that fair market value was received. The investigator is also instructed to request that the claimant submit any pertinent documentary evidence, as well as to gather statements from other individuals if material to the decision. The district court concluded that because the federal agency requires examination of more than a single statement of intent or of ignorance of the transfer of assets rule and indicates that documentary evidence may be significant in meeting the burden of proof, the new Virginia rule is consistent with the agency's interpretation. Therefore, concluding that the new rule's burden of proof provisions are "not more restrictive" than the § 1382b(c)(2) SSI rule's burden provision, the district court approved the new rule.

[2] We cannot agree with the district court. Although we concur in its judgment that a single subjective statement of intent will not constitute convincing evidence, we do not read the Virginia rule as stopping there. Rather, the Virginia rule requires documentary evidence in every case. By contrast, both the HHS regulations and the SSI claims manual strongly suggest that although objective evidence is persuasive, it need not be presented in every case. This is reinforced by the language of § 1382b(c)(2), which simply requires that the claimant come forward with "convincing evidence," without demanding from every claimant "objective" convincing evidence.

Moreover, we cannot approve the Virginia rule's requirement that the claimant provide evidence that establishes that other resources were available, at the time of the trans-

fer, to cover present and expected future medical expenses. It is true that the SSI manual instructs investigators to inquire into this question. But that is far less than an ironclad requirement that claimants in each case present objective evidence demonstrating their solvency on the date of the transfer exclusive of the property which is transferred. The high improbability that all of the aged, blind, and disabled at the lowest income levels will be able, regardless of their purpose in making the transfer, objectively to demonstrate that their resources at the time of the transfer had been sufficient to cover their future medical needs would enable Virginia to disqualify far more of this group than Congress intended. We think that they should not be rendered ineligible if by other credible evidence, short of documentary proof, they can establish that theirs was a lawful purpose. As we think that neither the Act itself nor the agency interpretations require the demonstration insisted on by the new rule, this part of the new rule cannot stand.

We hold therefore that these portions of the new Virginia rule are invalid under 42 U.S.C. § 1396a(j)(1), and may no longer be enforced by the Commonwealth. In addition, we remand this issue to the district court for the fashioning of relief for claimants whose federal rights have been violated by the imposition of this excessive burden of proof.

IV.

[3] We come now to the issue of whether the new rule—apart from the burden of proof provisions which we hold invalid—can lawfully be applied to persons whose initial applications for Medicaid were filed before July 1, 1981, the effective date of the Boren-Long Amendment (and of the new rule). Such persons fall into two classes: (1) those whose initial applications were filed prior to July 1, 1981,

but not acted upon until on or after that date; and (2) those who already were receiving Medicaid as of July 1, 1981, and to whom the new rule was applied during an annual eligibility redetermination (i.e., they had transferred assets for less than fair market value while receiving assistance, in order to remain eligible) after that date.

The Boren-Long Amendment, authorizing the application of transfer of assets rules, contained two "effective date" provisions. Section 5(c) of the Amendment specified that the addition of the SSI transfer of assets rule, 42 U.S.C. § 1382b(c), "shall be effective with respect to applications for benefits under title XVI of the Social Security Act [i.e., SSI] filed on or after" March 1, 1981. Section 2 of the Amendment broadly provided that "[t]he amendments made by this Act shall take effect on, and apply to services furnished on or after, July 1, 1981."

The district court ruled that Virginia cannot apply its new rule, whether as to the initial application or upon redetermination, to any person whose initial application was filed prior to July 1, 1981. The court noted that the SSI transfer of assets rule specifically is to be applied only prospectively to those persons whose applications were (and are) filed on or after March 1, 1981. The court then noted that under 42 U.S.C. § 1396a(f), Virginia as a § 209(b) state cannot apply any eligibility rule more restrictive than those used by SSI unless that state rule was validly in effect on January 1, 1972. Reasoning that this limitation continues to apply, the district court concluded that Virginia can only apply its rule to persons whose initial applications were filed on or after July 1, 1981, in that Virginia otherwise would be applying an eligibility rule more restrictive than SSI.

We think, however, that the Commonwealth may lawfully apply its new rule both as to applications initially filed be-

fore, but processed on or after, July 1, 1981, and as to all redeterminations made on or after July 1, 1981. First, the literal language of the Amendment suggests this. The effective date of the provision limiting application of the SSI transfer of assets rule to applications filed on or after March 1, 1981 by its terms applies only to SSI applications. By contrast, section 2 of the Amendment specifies that other changes made by the Amendment will apply to services furnished on or after July 1, 1981. This indicates that Congress intended that in connection with claims for assistance or reimbursement (services) filed on or after July 1, 1981, the states are permitted to apply the new transfer rules, which by their plain terms look back two years. Moreover, a contrary interpretation would create a grandfathered class of Medicaid recipients, who would not be limited by any restraint in their ability to transfer assets for less than their fair market value in order to remain eligible for assistance.[18]

We disagree, in addition, with the district court's rationale, because we think it clear that when Congress authorized the states to apply transfer of assets rules "[n]otwithstanding any other provision of this title," 42 U.S.C. § 1396a(j)(1), it intended, for purposes of such rules, to exempt states from the requirement in § 1396a(f) that § 209(b) states employ eligibility rules more restrictive than SSI only if those rules were in effect on January 1, 1972. Therefore, while it is true that by applying to persons whose initial applications were filed prior to July 1, 1981, Virginia's rule runs afoul of § 1396a(f) by denying medical assistance to persons eligible for SSI, that transgression is authorized by § 1396a(j)(1). For these reasons, the district court's order granting relief to the second class of plaintiffs is reversed, and Virginia may apply the valid portions of its new rule to that class.

V.

The Commonwealth also appeals from the district court's order that all members of the first class be given notice that their federal rights were violated, their federal lawsuit had come to an end, and they may attempt to seek reimbursement for past medical expenses through state proceedings. The Commonwealth urges that this order would violate the Eleventh Amendment because no state administrative remedies exist whereby plaintiffs can seek reimbursement for such expenses and because the costs of providing notice would allegedly be substantial.

[4] The doctrinal dividing line between relief permissible under the Eleventh Amendment and relief barred by its reservation of sovereign immunity is, in broadest form, that between prospective and retroactive relief. In *Ex parte Young*, 209 U.S. 123, 28 S.Ct. 441, 52 L.Ed. 714 (1908), the Supreme Court ruled that a federal court may order state officials to conform their future conduct to the requirements of federal law, even though such an injunction may have an ancillary effect on the state treasury. But in *Edelman* v. *Jordan*, 415 U.S. 651, 94 S.Ct. 1347, 39 L.Ed.2d 662 (1974), the Court held that the Eleventh Amendment bars suits by private parties seeking to impose a liability for the past conduct of state officers that must be paid from public funds in a state treasury.

Between these two poles and most relevant to the present case is *Quern* v. *Jordan*, 440 U.S. 332, 99 S.Ct. 1139, 59 L.Ed.2d 358 (1979). There, the district court had ruled that plaintiff applicants' federal rights in a public assistance program had been, and still were being, violated. As part of an order that also included prospective injunctive relief, the lower court required state officials to send a "mere explanatory notice to applicants advising them that there is a state

administrative procedure available if they desire to have the state determine whether or not they may be eligible for past benefits." *Id.* at 336, 99 S.Ct. at 1142, quoting 563 F.2d at 875. The Supreme Court rejected the state's argument that this violated the Eleventh Amendment. The Court emphasized that the notice did not purport to impose upon the state any liability for reimbursements; whether or not to do so was left to future state proceedings. Rather, said the Court, "[t]he notice in effect simply informs class members that their federal suit is at an end, that the federal court can provide them with no further relief, and that there are existing state administrative procedures which they may wish to pursue." 440 U.S. at 349, 99 S.Ct. at 1149. The Court's opinion indicates that these existing state remedies may include judicial, as well as administrative, proceedings. *Id.* at 349 & n. 20, 99 S.Ct. at 1149 & n. 20. As such, the Court found that the giving of notice—whose costs of preparation and mailing would be de minimis, *see id.* at 347 n. 19, 99 S.Ct. at 1148 n. 19—was properly viewed as ancillary to the prospective relief already granted by the lower court, rather than as a retroactive award of funds. *Id.* at 349, 99 S.Ct. at 1149.

Virginia argues first that here, unlike in *Quern,* there are no existing state administrative procedures whereby plaintiffs can seek reimbursement for past expenses. We note, however, that under 42 U.S.C. § 1396a(a)(3) the state Medicaid plan must "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied." Under the implementing regulations, 42 C.F.R. § 431.-220, this includes any applicant who is denied assistance, as well as any recipient whose assistance is discontinued. And, under 42 C.F.R. § 431.246, "if . . . [t]he hear-

ing decision is favorable to the applicant," then the state "agency must promptly make corrective payments, retroactive to the date an incorrect action was taken." Therefore, all participating states are required to have state procedures whereby applicants and recipients denied assistance may appeal that decision and, if they prevail at the hearing, receive benefits retroactive to the time of the incorrect decision.

The Commonwealth does not deny that it has such procedures. It maintains, however, that under its "Virginia Medical Assistance Program Appeals Procedure" the time limit for requesting such a hearing has expired for every member of the plaintiff class. Under 42 C.F.R. § 431.221, the state must allow a reasonable time for the applicant to request a hearing, but this is not to exceed ninety days from the date of decision. Virginia has chosen, under its appeals procedure, to require requests for hearings to be made within thirty days from the date of decision.

We think that at least two possible avenues of state relief are open. First, the Virginia procedures state that failure to comply with the thirty-day time limit may be excused for good cause shown. We think it possible that the state might construe its own erroneous interpretation of federal law as good cause for the failure of plaintiffs to bring their appeals sooner.

Second, under Virginia law, pecuniary claims against the state may be brought in state court within three years of their disallowance by the responsible agency. Va. Code § 8.01-255. Therefore, many of the claims by members of the first plaintiff class are still within the limitations period for filing in state court. We think that this is sufficient to satisfy *Quern*. First, *Quern* specifically refers to state judicial proceedings to determine reimbursement. 440 U.S. at

349 & n. 20, 99 S.Ct. at 1149 & n. 20. Second, the rationale in *Quern* was that although a federal court cannot order monetary relief for past unconstitutional state conduct, it can, where the state has chosen to provide a remedy for that conduct, require notice to the aggrieved individuals. We think it of no moment that the existing state remedy here may be judicial rather than administrative; in either case the state has voluntarily established a state remedy for its past violations of federal law and it is in the interest of the federal court so to inform the plaintiffs. We therefore conclude that this aspect of *Quern* is satisfied here.

The Commonwealth's second argument is that the district court's order to give notice is barred by the Eleventh Amendment because it would have more than a de minimis effect on the state treasury. We do not think that the state has demonstrated such an effect.[19] As part of the prospective relief, Virginia has been ordered to determine the identity of all members of the first class, so that those members otherwise currently eligible for Medicaid will be declared eligible. This requirement already involves the state in identifying all the class members; thus that part of the cost of giving them notice is already elsewhere required. In addition, some of these people will be determined to be currently eligible. Some notice must be given them of this decision. To enclose the extra information regarding the past violation of their rights will involve essentially no expense. Under these circumstances, the marginal costs of compliance with the notice order—the costs of printing the notices and of mailing them to persons who would not otherwise receive a mailing as part of prospective relief—have not been shown to be substantial.[20]

[5] In sum, we see no constitutional infirmity in the district court's ordering defendants to give notice to members

of the first class whose rights may have been violated both of that fact and of the further fact that these clients may have administrative or judicial redress under Virginia law. We perceive, however, a defect in the notice approved by the district court. That notice advises those to whom it is addressed that the Virginia Department of Welfare is "obligated" to redetermine their *past* eligibility, to reimburse expenses during that earlier period if the person would otherwise have been eligible, and to provide a hearing if disputes arise over the amount of reimbursement due. It is clear, however, that Virginia cannot be "obligated" by federal law to do any of these things, because they involve the mandating of retroactive monetary payments. Instead, the notice simply should explain the rulings of the present case, advise of the case's termination, and explain that the persons will have to look to state administrative or judicial remedies, if any, for possible retroactive reimbursement. It follows that even though we affirm the district court's order that Virginia send notices, on remand the notices must be amended to conform to this opinion.

AFFIRMED IN PART; REVERSED IN PART; AND REMANDED.

DONALD RUSSELL, Circuit Judge, dissenting:

This appeal turns on the resolution of two issues. The first and most important is whether Virginia, as a "§ 209(b)" participating State under the federal Medicaid program adopted as a part of the Social Security Act of 1965, was entitled, prior to the effective date of the Boren-Long Amendment in 1980,[21] to enforce its transfer of assets rule, which was a part of its approved participating Medicaid plan, as of January 1, 1972. The majority's answer to this

question is that Virginia could not because the rule conflicts with the proper construction of the provisions of the initial federal statute for state participation in the program and with the regulations of the Secretary of Health and Human Services (Secretary) issued thereunder. I disagree.

In *Schweiker* v. *Gray Panthers,* 453 U.S. 34, 43-44, 101 S.Ct. 2633, 2640, 69 L.Ed.2d 460 (1981), the Supreme Court stated the principles to guide courts in the construction and application of the statutory authorization for the Medicaid program. In that connection, it said that because of the "byzantine construction" of the statute creating such program, which was "among the most intricate ever drafted by Congress," Congress had "conferred on the Secretary exceptionally broad authority to prescribe standards" as provided for in the statute and to define statutory "terms," an authority which, when exercised, was to be given, as it were, " ' legislative effect' " and, in particular, it " 'entrust[ed] to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term,' " including in particular the term " 'available' " as used in the federal statute to designate for Medicaid eligibility thereunder.[22]

The federal statute creating this Medicaid program contemplated joint federal and state participation. In order to induce state participation, the federal government offered to make grants to participating states which submitted plans conforming to the standards fixed in the federal statute by the Congress and had been approved as so conforming, by the Secretary. § 1396, 42 U.S.C. Virginia submitted such a proposed plan shortly after the statute was enacted. Included in that plan was a transfer of assets provision under which any applicant or recipient who transferred property for less than its fair market value for the purpose of obtain-

ing Medicaid coverage was ineligible for participation in the program for a period of one year, subject to certain exceptions.[23] This provision was similar to plans submitted by many other states. The Secretary perceived in such provisions, manifestly designed to frustrate abuse of the program, nothing at variance with the broad purposes of the Act or its language if given the pragmatic interpretation intended by Congress, or with his regulations. It accordingly from the beginning of the program approved such provisions as valid and made grants under the Act to the states submitting plans which included such provisions.[24]

In 1972, Congress contemplated, in the course of replacing certain of the categorical assistance programs with what was known as the Supplementary Security Income (SSI) program, to change Medicaid eligibility to parallel SSI rules of eligibility. Congress feared, however, that, if this were done uniformly the burden in the case of those states with approved Medicaid plans less favorable to recipients than the SSI standards would induce many to withdraw with serious consequences for the program. Accordingly, Congress proceeded in the amendment to the Act, adopted at that time, to give "the states an option to limit Medicaid assistance to people who would have been eligible under the state's plan that was in effect on January 1 of that year (1972)." *Synesael* v. *Ling*, 691 F.2d 1213, 1214 (7th Cir.1982). In effect, by this amendment Congress represented to the states, as an inducement to remain as a participant in the program, that any state, at its option, could elect, rather than following the SSI schedule of benefits, to retain its limits on benefits established by its plan to recipients of Medicaid assistance as set forth in its approved plan in effect on January 1, 1972, *including by necessary implication its transfer of assets provisions*. The states exercising

such option were known as "Section 209(b)" states; those states, on the other hand, which elected to accept the broad SSI coverage, were known as "SSI" states. Virginia was one of almost half the states which elected to become a "Section 209(b)" state, accepting Congress' assurances that it was thereby limiting its burden by the provisions of its approved plan in effect on January 1, 1972. Thus, until the effective date of the Boren-Long Amendment to the Act in 1981, the participating states under the Medicaid program were divided into two classes, one, "Section 209(b)" states, and, two, "SSI" states, in which the provisions for assistance were expected to be different. During all of this period Virginia was a "Section 209(b)" state, operating under its approved plan in effect on January 1, 1972 with the transfer of assets provision.

After the adoption of this amendment creating the two classes of participating states, the Secretary recognized that "Section 209(b)" states, such as Virginia, could, unlike the "SSI" states, follow their approved plan of benefits in effect on January 1, 1972, including their transfer of assets provision, and continue to receive grants under the statute as a conforming state. The Secretary has never apparently departed from this position and he is before this Court in this case asserting the right of "§ 209(b)" states, such as Virginia, to enforce, prior to the effective date of the Boren-Long Amendment, their transfer of assets provisions if such provisions were a part of their approved plan on January 1, 1972.

Moreover, Congress itself knew of and implicitly approved of the Secretary's application and interpretation of the amendment. It violates common sense to assume that Congress was unaware throughout the '70s that "§ 209(b)" states were applying transfer of assets limitations, although

"SSI" states were forbidden to do so by the amendment of 1972. Any doubt on this point is dissipated by the legislative history leading up to the Boren-Long Amendment itself. In 1980 the reports of the various Congressional Committees, particularly that set forth on pp. 5596-97, U.S. Code Cong. & Admin. News, 96th Cong., 2d Sess., (1980), show beyond question that Congress was completely aware of this difference between the "SSI" states and the "§ 209(b)" states in connection with the authority to provide against transfer of assets and that it (Congress) approved of such difference as within Congressional intendment. Beyond this, the Supreme Court has recognized the difference in authority in this area between "§ 209(b)" states and "SSI" states. In *Gray Panthers* it said: "States exercising the § 209(b) option were required to adopt a 'spend down' provision." (453 U.S. at 39, n. 5, 101 S.Ct. at 2638, n. 5) Later, in *Schweiker* v. *Hogan*, 457 U.S. 569, 581, n. 18, 102 S.Ct. 2597, 2605, n. 18, 73 L.Ed.2d 227, 237, n. 18, the Supreme Court restated what it had said in *Gray Panthers* in this regard:

> "Since recipients of categorical welfare assistance are also entitled to Medicaid benefits, the expansion of general welfare accomplished by the SSI program increased Medicaid obligations for some States. To guarantee that States would not, for that reason, withdraw from the Medicaid program, Congress offered what has become known as the '§ 209(b) option.' Under it, States may elect to provide Medicaid assistance only to those individuals who would have been eligible under the state Medicaid plan in effect on January 1, 1972. . . . Thus, in some States, Medicaid is not automatically available for all of the 'categorically needy.' "

To summarize: (1) The Secretary, to whom the authority to interpret this statute was delegated under what the Su-

preme Court has characterized as an "exceptionally broad authority," has consistently and does now assert that "§ 209(b)" states had absolutely valid authority prior to the effective date of Boren-Long to have their own transfer of assets rule in their plan of Medicaid assistance; (2) Congress was aware of this construction of the statute by the Secretary and implicitly approved of it as a proper application of what it intended by the 1972 amendment; (3) And, as I read *Gray Panthers* and *Hogan,* both, in my opinion, read the authority of the Secretary and the effect of the 1972 amendment as sustaining the right of "§ 209(b)" states, prior to the Boren-Long Amendment, to enforce a transfer of assets rule.

The majority, however, disagrees. It concedes, as I read the majority opinion, that Congress by the amendment of 1972 created two classes of participating states under the federal Medicaid program, *i.e.,* the "§ 209(b)" class and the "SSI" class. It recognizes, I think, that Congress intended to make a distinction in what might be contained in the plan of the two classes: A "SSI" state was bound strictly to the limitations on benefits stated in the statute but a "§ 209(b)" state could be more flexible in its limitations on benefits, fixing its limitations or restrictions by what was a part of its plan, as approved by the Secretary, in effect on January 1, 1972. It is at this point, though, that the majority would add what I regard as an untenable qualification upon the right of a "§ 209(b)" state. Under its construction of the statute, a "§ 209(b)" state might not include in its plan any denial of participation in benefits in the plan which takes into account "resources" not "available" *in hand* to the applicant at the time of his application. This, it holds, is the inescapable result of § 1396a of the original statute. Under this construction, it would hold that, irrespective of

whether a transfer of assets provision be deemed a standard of eligibility or an anti-fraud provision, such a provision was invalid prior to the enactment of Boren-Long.

I disagree with this strict and inflexible construction of the statute. I do not tarry over the exact identification of a transfer of assets provision as a standard of eligibility or as an anti-fraud provision. I would find the provision valid in either circumstance, even though I think it is more properly considered an anti-fraud provision. The suggestion that *Fabula* v. *Buck*, 598 F.2d 869 (4th Cir.1979) brands the provision with invalidity if deemed an anti-fraud statute is, I suggest, unsound. *Fabula* dealt with a "SSI" state and the Secretary had long ruled after the 1972 amendment that a "SSI" state, as contrasted with a "§ 209(b)" state, could not include a transfer of assets provision in its plan. We held in *Fabula*—and this was the rationale of the decision—that "these administrative interpretations [by the Secretary] are reasonable and consistent with the statute, and are entitled to be followed by the courts." *Id.*, at 873. But, in the case of a "§ 209(b)" state, on the other hand, the Secretary has equally consistently taken the position that a transfer of assets provision was, until the effective date of the Boren-Long Amendment, a valid part of the state plan. Accordingly, if we follow the rationale of *Fabula*, that ruling of the Secretary with reference to a "§ 209(b)" state such as Virginia is "entitled to be followed by the courts," especially in the light of the rule of construction of the statute as stated by the Supreme Court in *Gray Panthers*. If, on the other hand, the provision is to be regarded as controlled by the term "available," then the Secretary had the authority to include within the term "available" anything that could reasonably have been "deemed" "available" under the decision in *Gray Panthers*, which was decided subsequently to

Fabula. I find nothing irrational in treating as a part of an applicant's "resources," assets which the applicant, in order to induce the Government to provide him with free medical attention on the representation that he was without "resources," had transferred his property to his children without consideration. I perceive little difference between such assets so transferred and assets which have been concealed or sequestered; in either instance, I think it reasonable to regard the assets as "available." Above and beyond this is the fact that, as already observed, under the 1972 amendment, Congress and the Secretary have both made a distinction between "SSI" states and "§ 209(b)" states but the majority opinion would, in disregard of that manifest purpose, eliminate that distinction.

I respectfully suggest, with all deference for the contrary views of the majority, that it (the majority), in declaring by its ruling that the rights of "§ 209(b)" and "SSI" states were identical in their limitations on benefits, is actually contradicting the representation made by Congress in its 1972 amendment that any provision limiting benefits which a state had in its plan in effect on January 1, 1972, would be permitted to continue if the state elected to become what was known as a "§ 209(b)" state. Frankly, I do not think Congress when it enacted the 1972 amendment, was engaging in a "shell game" of cleverly representing to states with transfer of assets provisions in their plans that they could, by exercising their option under § 209(b), continue to follow such provisions as were in effect in their participating plans on January 1, 1972, while concealing from them at the same time that such representation was valueless since its enforceability of the representation was invalid under the narrow construction of § 1396a, adopted by the majority. I repeat that it is my considered opinion that Congress, in its

1972 amendment, was telling in good faith any state whose existing participating plan had been approved by the Secretary as conforming with statutory standards that it could legally continue at its option to follow that plan, and it did not intend for any court in 1983 to invalidate provisions in a state plan which for more than a decade the Secretary, with the tacit approval of Congress, had found to be valid under the statute. Such action is, in effect, contrary to Congressional intent, as found in *Gray Panthers* that it was the Secretary and not the courts, to whom the Congress entrusted the authority to define the terms under the statute and to construe its provisions.

It follows that, under the above reasoning, I, unlike the majority would reverse the ruling of the District Court that the enforcement of Virginia's transfer of assets provision in its plan of participation in the Medicaid program prior to the effective date of the Boren-Long Amendment was invalid. Such a result, which follows generally the reasoning in *Synesael* v. *Ling, supra,* would render inappropriate all the remedial provisions of the District Court's judgment based on the assumed invalidity of the state's transfer of assets provision in existence prior to the effective date of the Boren-Long Amendment. This would leave for decision the challenge to the Virginia transfer of assets provisions in its plan of participation, as amended to conform to the requirements of the Boren-Long Amendment. Such challenge presents the second issue in this appeal.

The second issue in this case is the validity of Virginia's amended plan, as approved by the Secretary in compliance with the statute as amended. The District Court found such amended plan valid. The majority opinion finds it, in part, invalid. I again disagree. I would affirm the result on this issue reached by the District Court for the reasons assigned by it.

NOTES

[1] The text of 45 C.F.R. § 248.21(a)(2)(i) (1972) was:

> Financial eligibility—medical assistance programs.
>
> (a) *State plan requirements.* A State plan under title XIX of the Social Security Act must: . . . (2) With respect to both the categorically needy and, if they are included in the plan, the medically needy:
>
> (i) provide that only such income and resources as are actually available will be considered . . . .

[2] 42 U.S.C. § 1396a(f) provides:

> Notwithstanding any other provision of this subchapter, . . . no State . . . shall be required to provide medical assistance to any aged, blind or disabled individual . . . for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month . . . .

[3] In Virginia, Medicaid eligibility is routinely redetermined every twelve months, leading to application of the transfer of assets rule to individuals who transfer assets lest their improved financial condition disqualify them from continued assistance.

[4] The full text of the rule, as of January 1, 1972, read:

> An applicant for or recipient of medicaid as a recipient of SSI or a category related to a medically needy individual is ineligible for a period of one year if he transfers or otherwise disposes of his legal or equitable interest in real or personal property within one year prior to application or during receipt of such assistance to become or remain eligible for Medicaid. The transfer or disposal of such property to become or remain eligible for SSI is considered as if the transfer or disposal is to become or remain eligible for Medicaid.
>
> Exceptions to this provision are: (1) when property has been transferred that would have no effect on eligibility except a residence when an individual is in a nursing home for a temporary period; (2) when payment has been made approximating the tax value of the property; (3) when payment has been made on the cost of medical care approximating the tax value of the property; or (4) when the property owner has been a victim of actions on the part of another person who for any reason obtained the property without the applicant's/recipient's full understanding of the action.

Virginia State Dep't. of Welfare Medicaid Manual §§ 201.1A.3(2), 301.1(D)(3), and 402.1(B)(3).

[5] 42 U.S.C. § 1382b(c), establishing a transfer of assets rule for SSI eligibility, provides:

> (c)(1) In determining the resources of an individual (and his

eligible spouse, if any) there shall be included (but subject to the exclusions under subsection (a) of this section) any resource (or interest therein) owned by such individual or eligible spouse within the preceding 24 months if such individual or eligible spouse gave away or sold such resource or interest at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits or assistance under this capter.

(2) Any transaction described in paragraph (1) shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this chapter unless such individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

(3) For purpose of paragraph (1) the value of such a resource or interest shall be the fair market value of such resource or interest at the time it was sold or given away, less the amount of compensation received for such resource or interest, if any.

42 U.S.C. § 1396a(j), establishing a transfer of assets rule for Medicaid plans, provides:

(j)(1) Notwithstanding any other provision of this subchapter, an individual who would otherwise be eligible for medical assistance under the State plan approved under this subchapter may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1382b(c) of this title.

(2) In any case where the uncompensated value of disposed of resources exceeds $12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligibility exceeding 24 months, such plan shall provide for the period of ineligibility to bear a reasonable relationship to such uncompensated value.

(3) ....

[6] Virginia's new rule provides, in relevant part: *Property Transfer* —Any applicant for Medicaid benefits is ineligible for a specified period of time if he/she improperly transfers or otherwise disposes of his/her legal or equitable interest in real or personal property without adequate compensation within two years prior to application for assistance. A recipient of Medicaid benefits is ineligible for a specified period of time if he/she improperly transfers or otherwise disposes of his/her legal or equitable interest in real or personal property within two years of the discovery of that transfer. Such a transfer of

property will result in the ineligibility of the assistance unit for two years from the date of transfer if the uncompensated value was $12,000 or less. The period of ineligibility will be increased two months for every $1,000 or part thereof of uncompensated value in excess of $12,000. The amount of the uncompensated value is the fair market value of the property, established for local tax purposes, less the amount of any compensation received for the property. Exceptions to this provision occur when:

> a. A transfer of property is not made in an effort to become or remain eligible for Medicaid or SSI. It will be the responsibility of the client to establish that such a transfer was not made in an effort to qualify for Medicaid or SSI. The client must provide objective evidence that the transfer was exclusively for another purpose. A subjective statement of intent or ignorance of the property transfer provision is not sufficient. The client must provide evidence that other resources were available, at the time of transfer, to meet current and expected needs of that client, including costs of nursing home care.

Virginia State Dep't. of Welfare Medicaid Manual §§ 301.1(D)(3) and 402.1(B)(3) (1981).

[7] The district court employed this date because it is two years prior to the date the lawsuit was filed, and 42 U.S.C. § 1983 has a two-year statute of limitations. We think it clear, however, that the date that plaintiffs' cause of action arose was the date that final unfavorable administrative action was taken, not the date that initial applications for assistance were filed. *See Bireline* v. *Seagondollar,* 567 F.2d 260, 263 (4 Cir. 1977) (the "federal rule establishes as the time of accrual that point in time when the plaintiff knows or has reason to know of the injury which is the basis of his action"), *cert. denied,* 444 U.S. 842, 100 S.Ct. 83, 62 L.Ed.2d 54 (1979). Moreover, the question of whether the date of accrual was tolled by the pursuit of administrative appeals was addressed in *Board of Regents* v. *Tomanio,* 446 U.S. 478, 483-86, 100 S.Ct. 1790, 1794-96, 64 L.Ed.2d 440 (1980). The Supreme Court there instructed that the question of whether pursuit of administrative remedies tolls the limitations period is to be determined by reference to state tolling law. Under Va. Code § 8.01-255, pecuniary claims against the state must first be presented to the Comptroller for administrative proceedings, and the statute of limitations for filing in state court runs only thereafter. We think that this indicates that Virginia intends that the limitations period for claims against the state be tolled by the pursuit of administrative remedies.

The district court is therefore instructed to expand the composition of the first and second classes so that they include all persons whose applications were filed prior to July 1, 1981 and finally, after any administrative proceedings, denied on or after April 24, 1978.

[8] Some of these people may actually have been denied assistance under the former rule (e.g., they applied in March, 1981, after transferring assets in December, 1980), but because their transfers were made on or after July 1, 1979, they could have been denied assistance under operation of the new rule when it became effective on July 1, 1981.

[9] The named plaintiffs who were representatives of the classes certified were also given individual relief. They were awarded reinstatement of Medicaid eligibility provided they demonstrated eligibility unrelated to the transfer of assets rule, the opportunity to present to welfare officials evidence of medical expenses which would have been paid under Virginia's Medicaid program but for application of the transfer rule, and access to the Virginia Medicaid program's administrative process or to any other administrative or judicial process if there are disputes as to whether and how much money they should be paid or reimbursed.

[10] Several district courts have also reached this conclusion. *See McFarland* v. *Mitchell,* C.A. # C-80-0325 (D. Utah 1982); *Dokos* v. *Miller,* 517 F.Supp. 1039 (N.D. Ill. 1981); *Woodward* v. *St. Clair,* C.A. # J78-0274(R) (S.D. Miss. 1980).

[11] *See* 453 U.S. at 44-48, 101 S.Ct. at 2640-2642. The Court cited § 1396a(a)(17)(D), which explicitly authorizes certain "deeming," as well as passages from both the House and Senate reports, which specifically indicate that "deeming" is authorized under the Act.

[12] We also cannot agree that a state has the inherent authority to enact collateral eligibility rules not in compliance with § 1396a(a)(17) simply because those rules attempt to deter fraud. In support of its argument, the Commonwealth cites *New York State Department of Social Services* v. *Dublino,* 413 U.S. 405, 93 S.Ct. 2507, 37 L.Ed.2d 688 (1973) (upholding a state rule requiring acceptance of employment as condition to receiving AFDC), and *Lavine* v. *Milne,* 424 U.S. 577, 96 S.Ct. 1010, 47 L.Ed.2d 249 (1976) (state rule prohibiting welfare payments to persons who quit their employment upheld). But in *Dublino* there was no federal provision inconsistent with the state rule, and in *Lavine* there was no federal provision involved at all, as the benefits were purely a matter of state law. Here the Commonwealth's rule was plainly inconsistent with controlling federal law.

[13] The revision of 45 C.F.R. § 248.3(b)(1) in 1977, *see* 42 Fed. Reg. 2684, 2686 (1977), to remove the word "actually" from the regulation's requirement that resources be available, did not, therefore, affect the former Virginia rule's invalidity. The rule's invalidity from 1974 on was due to its noncompliance with § 1396a(f), which as we have read it required the state to use only those restrictions lawfully in effect on January 1, 1972. Because Virginia's rule was not validly in effect on that date, only a change in the Act overriding

§ 1396a(f) could validate the rule. That change did not occur until passage of the Boren-Long Amendment.

Gray Panthers does not hold otherwise. It is true that the Court there unheld 1977 HEW regulations permitting liberal deeming of resources in § 209(b) States. But the Court made clear that such deeming had explicitly been authorized by Congress before January 1, 1972, and that such deeming rules had been consistent with § 1396(a)(17) on that date. The 1977 regulations, therefore, merely served to explicate the law as it had been since 1972, rather than to authorize state rules that were invalid in 1972. *See* 453 U.S. at 44-48, 101 S.Ct. at 2640-2642.

[14] Our conclusion on this issue also leads us to disagree with the implications in *Synesael* as to the effect of Boren-Long on the continued use by § 209(b) states of already-existing transfer of assets rules procedurally "more restrictive" than the SSI transfer of assets rule. *See infra* note 16.

[15] In regard to this conclusion, what we said in *Fabula,* 598 F.2d at 869, is again pertinent:

> While we sympathize with [the State's] desire to restrict its medical assistance benefits to those most in need, "a State's interest in preserving the fiscal integrity of its welfare program may not be protected by the device of adopting eligibility requirements restricting the class of [individuals] made eligible by federal standards." *Townsend* v. *Swank,* 404 U.S. 282, 291, 92 S.Ct. 502, 508, 30 L.Ed.2d 448 (1971).

[16] It is true that the panel majority in *Synesael* v. *Ling,* 691 F.2d 1213 (7 Cir. 1982), held that § 1396a(j) does not apply to the continued use by § 209(b) states of already-existing transfer of assets rules. But as discussed above, *see* pages 265-266 *supra,* the premise of that conclusion was an assumption that such rules were valid prior to Boren-Long and hence that their use could be "continued." Because our analysis constrains us to disagree with that assumption, and to conclude that Virginia's transfer rule was never valid prior to Boren-Long, we think that § 1396a(j) does apply to Virginia's current rule.

[17] *See supra* note 8.

[18] Such an interpretation would be especially disfavored in the Medicaid laws, because the standards for state Medicaid plans, unlike those for the SSI system, are explicitly required to be comparable for all groups of applicants and recipients. *See* 42 U.S.C. § 1396a(a)(17).

[19] We need not, therefore, decide whether the notice would be constitutionally impermissible if its costs were substantial.

[20] We do not, of course, here decide the permissibility of notice (or any other) relief for the second and third plaintiff classes injured by erroneous eligibility determinations based on the new Virginia

rule's excessive burden of proof provisions; such relief is to be fashioned in the first instance by the district court on remand.

[21] Pub.L. No. 96-611, § 5, 94 Stat. 3567 (1980), codified at 42 U.S.C. §§ 1382b(c) and 1396a(j).

[22] In line with this recognition of the interpretative authority having a "legislative effect" vested in the Secretary, the Supreme Court in *Gray Panthers* held that "resources" which could be considered "available" to an applicant might be *"deemed"* to include "resources" which were "available" to the applicant's spouse.

[23] The provision as of January 1, 1972, is set forth in the majority opinion in note 4.

[24] In *Fabula* v. *Buck*, 598 F.2d 869, 878 (4th Cir. 1979), we said that the approval of a state plan would, in that case, be but "slightly persuasive" on the validity of the plan but it said that because, as we were careful to observe, such approval was "in the face of the agency's clear statements to the contrary." In this case, however, the Secretary has consistently taken the position that a "§ 209(b)" state might validly enforce a transfer of assets provision prior to the adoption of the Boren-Long Amendment. This "clear" action of the Secretary over a long period of time gives to the construction of the statute urged by the State and the Secretary considerable "persuasiveness" in this case.

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

No. 82-1773

EVELYN RANDALL; EMMA MATTHEWS; ARCHIE MORSE; MINNIE MILLER, by her next friend, VIOLA LISKEY, on behalf of themselves and all others similarly situated,

and

MAGGIE LAMB; POMPEY WINGO; RACHEL WINGO and WILLIAM E. SMITH,

Appellees,

v.

WILLIAM L. LUKHARD, Comm. of the Commonwealth of VA Dept. of Welfare; DR. JAMES B. KENLEY, Comm. of Health for the Commonwealth of VA, and DR. FREEMAN C. HAYS, Dir. of VA Medical Assistance Program,

Appellants.

and

Richard Schweiker, Sec. H & H Services,

Amicus Curiae.

Gray Panthers

Amicus Curiae.

No. 82-1774

EVELYN RANDALL; EMMA MATTHEWS; ARCHIE MORSE; MINNIE MILLER, by her next friend, VIOLA LISKEY, on behalf of themselves and all others similarly situated,

and

MAGGIE LAMB; POMPEY WINGO; RACHEL WINGO and WILLIAM E. SMITH,

Appellants,

v.

WILLIAM L. LUKHARD, Comm. of the Commonwealth of VA Dept. of Welfare; DR. JAMES B. KENLEY, Comm. of Health for the Commonwealth of VA, and DR. FREEMAN C. HAYS, Dir. of VA Medical Assistance Program,

Appellees,

and

Richard Schweiker, Sec. H & H Services,

Defendant.

Gray Panthers, *Amicus Curiae.*

Appeals from the United States District Court for the Western District of Virginia, at Charlottesville. James C. Turk, Chief Judge. (C/A 80-0050)

On Petition for Rehearing:

Argued: December 5, 1983 Decided March 12, 1984

Before WINTER, Chief Judge, RUSSELL, WIDENER, HALL, PHILLIPS, MURNAGHAN, SPROUSE, ERVIN, and CHAPMAN, Circuit Judges, sitting in banc.

Herbert L. Beskin, Charlottesville-Albemarle Legal Aid Society (V. Anne Edenfield, Legal Aid Society of Roanoke Valley on brief) for Appellants in 82-1774 and for Appellees in 82-1773; Robert T. Adams, Assistant Attorney General (Gerald L. Baliles, Attorney General, John A. Rupp, Senior Assistant Attorney General on brief) for Appellants in 82-1773 and for Apellees in 82-1774; (Gill Deford, National Senior Citizens Law Center on brief) for Amicus Curiae, Gray Panthers.

WINTER, Chief Judge:

Before us on rehearing in banc are the issues decided by a divided panel in *Randall* v. *Lukhard,* 709 F.2d 257 (1983).* The majority ruled that:

> 1. Virginia's former "transfer of assets" eligibility rules for entitlement to medicaid benefits was invalid from January 1, 1972 until June 30, 1981 because it conflicted with federal law;
>
> 2. The burden of proof provisions to overcome presumptive ineligibility for medicaid benefits arising from a transfer of property of Virginia's new "transfer of assets" eligibility rule were invalid because they conflicted with federal law;
>
> 3. Virginia's new "transfer of assets" eligibility rule, aside from the invalid burden of proof provisions, could be applied to persons whose applications for medicaid were filed before July 1, 1981 and processed on or after July 1, 1981 and to all redeterminations of eligibility made on or after July 1, 1981; and
>
> 4. With a modification of the notice approved by the district court, Virginia was obliged to give notice to medicaid claimants who applied for benefits from April 24, 1978 through June 30, 1981 and who were denied benefits because of transfers made before July 1, 1979, of their possible right to state administrative or state judicial remedies.

Accordingly, we affirmed in part and reversed in part the judgment of the district court and remanded the case for further proceedings.

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* The panel consisted of Winter, Chief Judge, Russell, Circuit Judge, and Fairchild, Senior Circuit Judge for the Seventh Circuit, sitting by designation. Judges Winter and Fairchild comprised the majority, with Judge Russell in dissent.

On rehearing we adopt holdings numbers 1, 3 and 4 (as summarized above) for the reasons expressed in the majority panel opinion. As to those issues, we adopt the majority panel opinion as the opinion of the in banc court.

We conclude, however, that the burden of proof provisions to overcome presumptive ineligibility for medicaid benefits arising from a transfer of property under Virginia's new "transfer of assets" eligibility rule do not conflict with federal law and are not therefore invalid. Our reasons are set forth in the following section of this opinion.

II.

As pointed out in the majority panel opinion, *Id.* 261-62, in December 1980 the Boren-Long Amendment was signed into law. Pub. L. No. 96-611, 94 Stat. 3567 (1980). The Amendment, *inter alia,* created a transfer of assets eligibility rule for the Supplementary Security Income (SSI) program and authorized the states to adopt a similar transfer of assets eligibility rule for their medicaid programs. 42 U.S.C. §§ 1382b(c) and 1396a(j). The language with which we are concerned is that contained in § 1382b(c)(2), which in pertinent part reads:

> Any transaction. . . shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this chapter unless such individual or eligible spouse furnishes *convincing evidence* to establish that the transaction was exclusively for some other purpose. [emphasis added]

Section 1396a(j)(1) authorized the states to incorporate similar transfer of assets rules in their medicaid programs but that section provided.*

* We note that this provision was recodified by the Tax Equity and Fiscal Responsibility Act of 1982, PL 97-248 § 132(c). An identical rule may now be found at 42 U.S.C. § 1396p(c)(1) (1982).

> If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2) [length of disqualification], is not more restrictive than the procedure specified in section 1382b(c) of this title.

Acting upon the authorization contained in the 1980 amendment, Virginia rewrote its manual with respect to the measure of proof necessary to overcome the disqualifying statutory presumption:

> It will be the responsibility of the client to establish that such a transfer was not made in an effort to qualify for Medicaid or SSI. The client must provide objective evidence that the transfer was exclusively for another purpose. A subjective statement of intent or ignorance of the property transfer provision is not sufficient. The client must provide evidence that other resources were available, at the time of transfer, to meet current and expected needs of that client, including cost of nursing home care. Virginia Manual sections 301.1 D.3.a. and 402.1 B.3.a.

The state rule requires that: a presumptively ineligible claimant must provide "objective" evidence that he transferred assets exclusively for a purpose other than to establish medicaid eligibility; he cannot rely solely on a subjective statement of intent or ignorance of the law; and he must show that at the time of the transfer there were other assets available to meet his current and expected medical needs. The precise issue before us is whether those requirements conflict with the federal standard of "convincing evidence" to establish that the transfer was not exclusively to create eligibility. The district court ruled that there was no conflict and we agree.

The standard prescribed by § 1382b(c)(2) has been administratively construed by the Department of Health and Human Services in A12505.S of the SSI Claims Manual (revised as of October, 1983). The criteria identified seem to indicate that something more than merely the claimant's unsupported statement is required. To like effect is the proposed regulation to be codified as 20 C.F.R. § 416.1246(e). *See* 46 Fed. Reg. No. 204 51779 (October 22, 1981).

The contention of Evelyn Randall and the other plaintiffs that the Virginia standard conflicts with the federal standard reduces itself to the assertion that Virginia's requirement of "objective evidence" means documentary evidence and nothing in the federal standard of "convincing evidence", or the administrative interpretations of the federal standard, is this restrictive; hence the conflict. On the surface the argument is appealing and the majority panel opinion adopted it. That construction, however, is not required, and its incorrectness is made apparent by the post-decision brief filed by Virginia in connection with rehearing in banc. There, after quoting the current Virginia rule, Virginia asserts:

> Nowhere in this language is there an exclusive requirement for documentary evidence; oral evidence is accepted. Objective evidence is simply that evidence which rational people agree is real or valid. . . . In short, "objective" is not tantamount to "documentary", and Virginia has never held otherwise.

We accept Virginia's description of the operation and effect of its regulation and conclude that it does not conflict with applicable federal law and hence is valid.

III.

For the reasons set forth above and those contained in the portions of the majority panel opinion which we adopt, the judgment of the district court is affirmed in part and reversed in part and the case is remanded for further proceedings.

AFFIRMED IN PART;
REVERSED IN PART; AND
REMANDED.

MURNAGHAN, Circuit Judge dissenting:

In dissenting from the portion of the majority opinion that holds invalid, as in conflict with federal law, Virginia's former "transfer of assets" eligibility rules, certainly I join Judge Russell, who has said it very well in his terse dissenting opinion.

I wish also to express dissatisfaction with the majority's acceptance, at the expense of all adherence to true meaning, of a bureaucratic twisting of language appearing in the regulation purporting to interpret the statute. To disqualify an applicant for Medicaid from receipt of benefits under that program, it was proper for Virginia to take into account "income and resources. . . determined in accordance with standards prescribed by the Secretary [of Health and Human Services], available to the applicant or recipient. . . ." 42 U.S.C. § 1396a(a)17. The Secretary's regulation limited consideration to "such income and resources as are *actually* available." 45 C.F.R. § 248.21(a)(2)(i) (1972) (emphasis supplied).

The majority, I submit mistakenly, has opined that, in total disregard of responsibility to one's self or to one's fellow citizens, one, following the administrative interpretation of the statute, may reduce to mockery the clearly expressed congressional intention to impose a means test to judge qualification for Medicaid. In short, the majority seems to forget that it matters not one whit for us as judges whether Congress, in its legislative wisdom, acted prudently in imposing a means test. Anyone dastardly enough to deed away his house to children, a lady friend, or a male companion for the express and sole purpose of cheating the Government of its legal due emerges as unscathed, with full eligibility for Medicaid. Meanwhile, the would-be applicant with a modicum of decency and an unwillingness to sink

to such immoral depths, or even with a lack of shrewdness sufficient to conceive a shady practice of the sort here presented, is left out in the cold, required to sell his house and to invade the proceeds before coming entitled to Medicaid.

The arrangement appears to have been so open-ended that, on the basis of the approach taken by the majority, Scrooge, in the throes of terminal cancer, could disgorge his entire, and by no means insubstantial, fortune for any purpose, good, frivolous or evil, and then line up to sup at the public Medicaid trough. For me, Congress neither meant nor wrote to permit such a mischievous practice.

We all must agree that great latitude should be allowed an administrator in interpreting a statute confided to his safekeeping. Still, there is a line that may not be overstepped. A regulation saying "black" when Congress has provided that only white handkerchiefs may be utilized (perhaps because of perceived health threats from dyes commonly employed) will not be accorded "due deference," or, to say it otherwise, deference would not, in such an extreme case, be due. The statute does not attempt to confer on the Secretary the right to determine, substantively, what is or is not an item of income or a resource. The administrative discretion is limited to the purely procedural question of how to identify what is income or a resource as determined by the statutory standards. The broad authority inhering in the Secretary to interpret "available" recognized in *Schweiker* v. *Gray Panthers,* 453 U.S. 34, 43-44 (1981) is not to be equated with total abdication by the legislative and judicial branches.

To the same effect is the consideration that a statutory amendment making pellucid the meaning of certain language in its application to a "transfer of assets" situation need not amount to a satisfaction with, or a concession as

to the accuracy of, a different interpretation theretofore given the language that is being amended. Congress may equally well amend to display its dissatisfaction with the interpretation and to express its well-founded belief that the wrong meaning has, all along, been assigned. *See SEC* v. *Sloan,* 436 U.S. 103 (1978) (mere reenactment of § 12(k) of Securities Act of 1934 does not constitute congressional approval of administrative interpretation theretofore given that section); and *Moore* v. *Harris,* 623 F.2d 908 (4th Cir. 1980) (1978 amendment to Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*, was designed to make unmistakable the intent of Congress that self-employed miners be eligible for benefits under the Act, notwithstanding prior administrative interpretation to the contrary). When Congress, in 1980, passed the Boren-Long Amendment, 42 U.S.C. § 1382b(c), operating to give certain transfers of property a disqualifying effect when determining Medicaid eligibility, absent convincing evidence of a *bona fide* reason for the transfer (*i.e.*, one not designed to establish or manufacture sham eligibility), it was merely stating that the earlier "actually available" regulation had been erroneously adopted, or at least erroneously construed.

Had Virginia been permitted to deny benefits in such transfer situations, it is reasonable to assume that many transferees, like the spouses dealt with in *Schweiker* v. *Gray Panthers, supra,* would have returned, and therefore have rendered "actually available," the dissipated assets. In all likelihood, the transferees were on extremely good terms with the transferors in order for the transactions originally to have taken place at all. In short, the relevance of *Schweiker* v. *Gray Panthers, supra,* lies in the conclusion that assets of a spouse, though not directly in the hands of the

applicant, could still be deemed to be available for purposes of the statute.

In bankruptcy law we do not permit such largely illusory transfers to deplete a debtor's estate. *See Gray* v. *Snyder*, 704 F.2d 709 (4th Cir. 1983) (trustee in bankruptcy may avoid debtor's transfer of property interest if debtor "received less than a reasonably equivalent value in exchange for such transfer," 11 U.S.C. § 548(a)(2)). While health concerns are more traumatic than financial ones, there are, nevertheless, additional considerations relating to the phychic health and wellbeing of the nation as a whole that also must be taken into account. Fair behavior of citizens to one another is the touchstone of a civilized state. Maintenance of fair treatment by individuals is a primary responsibility of government, including the courts, when decent action is not voluntary. A broad and general acceptance of court decisions, even by the losers, is a largely unmentioned marvel of the American system. Yet it should not be taken for granted. If it abates, so too do law and order in the most comprehensive sense of those terms. Misuse of the phrase in the political arena has led to slurs on "law and order," with a resulting curtailment of the broader meanings once given the terms. The mere fact of such misuse, however, does not itself constitute valid reason to dispose, impetuously in a swirl of soapy bathwater, of the concept as truly conceived and applied.

Law and order suffer a setback when fraud is held to have been congressionally authorized, if not, practically speaking encouraged. Dissatisfaction with the judicial system and with the Congress, as it has now been held by the majority to have acted, may be expected to grow. Such developments were not, however, truly intended by Congress. The language of the statute does not compel the result

reached by the majority. Indeed, if the Secretary had by regulation adopted what later became the language of the Boren-Long Amendment, the Secretary's interpretation would have been accepted by the Court. Both the Secretary and the Court would, in that case, be right. What the Secretary has done, however, is to defy logic and congressional intent. Consequently, his action and the affirming action of the majority are wrong.

Congress did not, looking at the matter in the round, intend to permit the raid on the Treasury sanctioned by the Secretary and approved by the majority. Congress meant that transfers, which, if not outright spurious, at least are deceptive in the extreme, should be deemed included in the category of "income and resources available to the applicant or recipient." Therefore, I dissent to that not-negligible extent from the opinion of the majority. Judge Russell, Judge Widener and Judge Chapman has each authorized me to state that he joins me in dissent.

RUSSELL, Circuit Judge, dissenting:

I dissent from part one of the *en banc* opinion herein for the same reasons as stated in my dissent to part one of the panel opinion.

Judge Widener and Judge Chapman concur in this dissent

APPENDIX B

App. 51

Evelyn RANDALL, et al., Plaintiffs.

v.

William LUKHARD, et al., Defendants.

Civ. A. No. 80-0050-C.

United Stated District Court,
W. D. Virginia,
Charlottesville Division.

April 16, 1982.

OPINION and ORDER

TURK, Chief Judge.

In an effort to prevent fraud in the use of Medicaid funds, the Commonwealth of Virginia has employed a transfer of assets rule which disqualifies those Medicaid applicants or recipients who have transferred property to other persons for a consideration which is less than the fair market value of the property. Plaintiffs filed this class action challenging the Commonwealth's transfer of assets rule on the grounds that the transfer rule, as it has existed in all of its forms since 1965, violated Title XIX of the Social Security Act, as amended, and also the due process and equal protection clauses of the fourteenth amendment. This court possesses jurisdiction of these matters pursuant to 28 U.S.C. § 1331 and 28 U.S.C. § 1343(3).

Congress established the Medicaid program in 1965 as Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq*. If a state chooses to participate in the program, the federal government will reimburse the state for a portion of the costs of medical treatment for needy persons. A participating state must develop a plan containing "reasonable

standards...for determining eligibility for and the extent of medical assistance." 42 U.S.C. § 1396a(a)(17). The plan must comply with the requirements imposed both by the Social Security Act and by the Secretary of Health and Human Services. *Id., Schweiker* v. *Gray Panthers,* 453 U.S. 34, 101 S.Ct. 2633, 2636, 69 L.Ed.2d 460 (1981).

When first enacted in 1965, Medicaid required participating states to provide medical assistance to "categorically needy" individuals. The "categorically needy" were persons eligible to receive cash payments under one of four welfare programs established elsewhere in the Act. 42 U.S.C. § 1396a(a)(10) (1970 ed.). A participating state also had the option, however, of providing medical assistance to the "medically needy," those persons who possessed incomes or resources too large to qualify for categorical welfare assistance, but too small to pay for their medical expenses. In assessing whether an individual qualified for medical assistance as either a "categorically needy" or "medically needy" person, a state was required to evaluate financial need using only "such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient." 42 U.S.C. § 1396a(a)(17)(B).

As of January 1, 1972, the standards promulgated by the Secretary to define the term "available" stated, in pertinent part,

> (a) *State Plan requirements:* A State plan under title XIX of the Social Security Act must:
>
> ....
>
> (2) With respect to both the categorically needy and, if they are included in the plan, the medically needy:

> (1) Provide that only such income and resources as *are actually available* will be considered and that income and resources will be reasonably evaluated. . . .

45 C.F.R. § 248.21(a)(2)(i) [1972] (later recodified at 42 C.F.R. § 448.3(b)(1)) (emphasis supplied).

Virginia chose to participate in the Medicaid program and, as of January 1, 1972, Virginia's program applied a transfer of assets rule to all applicants who sought medical assistance under the Old Age Assistance and Aid to the Permanently and Totally Disabled programs. In general the rule required an applicant who had transferred real or personal property within one or two years of the date of his application, for a consideration less than the fair market value of the property, to demonstrate that the transfer was not for the purpose of becoming eligible for Medicaid.[1]

In 1972 Congress revised the Social Security Act. The welfare programs aiding the aged, blind, and disabled (but not dependent children) were repealed, effective January 1, 1974. A new program, Supplemental Security Income for the Aged, Blind, and Disabled (SSI), gave the federal government the responsibility not only for partially funding payments but also for setting eligibility standards. 42 U.S.C. § 1381 *et seq.*, Pub.L. 92-603, 86 Stat. 1465 (1972). The SSI standards of need were more liberal than those used by some states under the previous state-run categorical need programs, and thus SSI confronted these states with the possibility of providing Medicaid assistance to a much larger number of persons.

"[I]n order not to impose a substantial fiscal burden on these States" or discourage them from participating in Medicaid, Congress created the "§ 209(b) option", S.Rep. No.553, 93d Cong., 1st Sess., 56 (1973). By exercising this option a state could ignore the more liberal SSI Medicaid eli-

gibility standards and provide Medicaid assistance only to those persons who would have been eligible for the state Medicaid plan in effect on January 1, 1972. 42 U.S.C. § 1396a. Virginia chose to exercise the § 209(b) option. Therefore the Commonwealth continued to apply a transfer of assets rule to aged, blind, and disabled applicants for Medicaid, as it had done on January 1, 1972.

Plaintiffs filed this class action on April 24, 1980, seeking declaratory and injunctive relief on the grounds that Virginia's transfer of assets rule violated Title XIX of the Social Security Act and the due process and equal protection clauses of the fourteenth amendment. Subsequently, on December 28, 1980, President Carter signed Amendment No. 1936 to the Pneumococcal Vaccine Act, H.R. 8406, Section 5 of Public Law 96-611 (the Boren-Long Amendment). Despite its title, the Amendment in part permitted all state Medical plans to employ a transfer of assets rule which presumed that a transfer of property for less than fair market value within the previous 24 months was for the purpose of becoming eligible for Medicaid.[2] To rebut the presumption an applicant must offer "convincing evidence" that the transfer was made exclusively for some other purpose. *Id.; codified at* 42 U.S.C. § 1382b(c)(2). Virginia accordingly developed a new transfer of assets rule to conform with the Boren-Long Amendment.[3] By leave of the Court plaintiffs then amended their complaint to challenge Virginia's new transfer rule as well as its previous rule.

Plaintiffs are various individuals who have either been disqualified from Medicaid eligibility at some time because of the transfer of assets rule or who have been informed by Virginia Medicaid officials that if they applied for Medicaid benefits, their application would be denied because of the transfer rule. Thus each plaintiff has either exhausted

his administration remedies or discovered that to do so would be futile. Plaintiffs now seek certification of three classes of individuals pursuant to Fed.R. Civ.P. 23(b)(2), as well as summary judgment against defendants in their official capacity as the Secretary of the United States Department of Health and Human Services, Commissioner of the Virginia Department of Welfare, the Commonwealth's Commissioner of Health, and the Director of the Virginia Medical Assistance Program. Defendants also have moved for summary judgment.

I.

[1] Pursuant to Rule 23(b)(2) of the Federal Rules of Civil Procedure, the Court will certify the following three classes of plaintiffs:

> (a) All those elderly, blind or disabled persons who (1) applied for Medicaid through the Virginia Medical Assistance Program before July 1, 1981; (2) at the time of their application met all the Medicaid eligibility requirements except the Virginia transfer of assets rule; and (3) were denied Medicaid because of the application of this rule to property which they transferred before July 1, 1979. Plaintiffs Morse and Miller represent this class.
>
> (b) All those elderly, blind or disabled persons who (1) applied for Medicaid through the Virginia Medical Assistance Program before July 1, 1981; (2) at the time of their application met all the Medicaid eligibility requirements except the Virginia transfer of assets rule; and (3) were denied Medicaid because of the application of this rule to property which they transferred on or after July 1, 1979. Plaintiffs Matthews, Lamb, Smith and Pompey and Rachel Wingo represent this class.

(c) All those elderly, blind or disabled persons who (1) applied for Medicaid through the Virginia Medical Assistance Program on or after July 1, 1981; (2) at the time of their application met all the Medicaid eligibility requirements except the requirements of the Virginia transfer of assets rule; and (3) were denied Medicaid benefits because of the application of the Virginia rule to property which they transferred on or after July 1, 1979. Plaintiff Evelyn Randall represents this class.

The record contains sufficient evidence that each class is so numerous that joinder of its members is impracticable; that common questions of law or fact exist; that plaintiffs' claims are typical of the claims of each class; and that each plaintiff is an adequate representative of his or her designated class. Furthermore, defendants have acted on grounds generally applicable to each class.

II.

[2] The Court finds that the transfer of assets rule employed in the Virginia Medicaid program prior to July 1, 1981, was inconsistent with section 1902(a)(17)(B) of the Social Security Act, 42 U.S.C. § 1396a(a)(17)(B). In particular, Virginia's former transfer rule violated the statutory requirement that a state plan take into account "only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant." *See* 42 U.S.C. § 1396a(a)(17)(B). Since the transfer rule is invalid in this regard, the Court declines to address plaintiff's other statutory and constitutional challenges to Virginia's former transfer rule. *See Swain* v. *Pressley*, 430 U.S. 372, 378 n. 11, 97 S.Ct. 1224, 1228 n. 11, 51 L.Ed.2d 411 (1977).

[3] As noted previously, in choosing the § 209(b) option Virginia could continue to apply the same eligibility standards it used on January 1, 1972. By enacting the § 209(b) option, however, Congress did not intend to validate every eligibility standard applied on January 1, 1972, without regard to its legality at that time. If a state regulation was invalid on January 1, 1972, under then-existing law, it was also invalid on January 1, 1974, when the § 209(b) option became available. As the Fifth Circuit stated in *Norman* v. *St. Clair,* 610 F.2d 1228 (5th Cir. 1980), *cert. denied,* 453 U.S. 922, 101 S.Ct. 3159, 69 L.Ed.2d 1005 (1981).

> Although § 209(b) allows states to use standards more restrictive than those under the SSI program, the provision can not be viewed as an all-purpose "grandfathering" clause which effectively legitimizes any and every provision appearing in a state plan in 1972. We find no indication that in passing § 209(b) Congress intended to authorize otherwise improper procedures. In other words, if, in January, 1972, the state's . . . procedure was impermissible under 42 U.S.C. § 1396a(a)(17), it cannot now be made acceptable simply because of § 209(b).

610 F.2d at 1235. *Accord, Lewis* v. *Shulimson,* 400 F.Supp. 807, 810 (E.D.Mo.1975), *aff'd,* 534 F.2d 794 (8th Cir. 1976), *cert. denied,* 430 U.S. 940, 97 S.Ct. 1570, 51 L.Ed.2d 786 (1977).

As of January 1, 1972, Virginia's transfer of assets rule directly contradicted the Secretary's prescription that a state plan consider only resources which "are actually available" in determining an applicant's eligibility for Medicaid. *See* 45 C.F.R. § 248.-21(a)(2)(i) [1972] (later recodified at 42 C.F.R. § 448.3(b)(1)). The transfer rules presumed that a Medicaid applicant possessed resources which he in fact did not possess at the time of his application. If an

applicant had transferred an asset prior to his application, that asset was not actually available to the applicant. By promulgating a regulation which violated the Secretary's own regulations, the Commonwealth in turn violated 42 U.S.C. § 1396a(a)(17)(B), which provides that states evaluate financial need using resources which are "available," "as determined in accordance with standards prescribed by the Secretary."

At least two other courts have also invalidated transfer of assets rules for that same reason. *See Dokos* v. *Miller,* 517 F.Supp. 1039 (N.D.Ill.1981), and *Woodard* v. *St. Clair,* No. J 78-0274(R) (S.D.Miss. Dec. 17, 1980). As the *Dokos* court stated, "the Federal provisions leave no room for recasting as 'actually available' any assets that the recipient or applicant has in fact relinquished." 517 F.Supp. at 1044. *See also Buckner* v. *Maher,* 424 F.Supp. 366 (D.Conn. 1976). *aff'd,* 434 U.S. 808, 98 S.Ct. 290, 54 L.Ed.2d 184 (1977). More importantly, the recent decision of the Supreme Court in *Schweiker* v. *Gray Panthers,* 453 U.S. 34, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981), supports this interpretation of the law.

In *Gray Panthers* plaintiffs challenged as arbitrary and capricious a *federal* regulation permitting states to count the income of a spouse as a portion of the income and resources available to a Medicaid applicant, even if the spouse's income was not actually contributed to the spouse. *See* 42 U.S.C. § 1396a(a)(17)(D); 42 C.F.R. § 435.723 (1981). The plaintiffs argued that this "deeming" of income violated § 1396a(a)(17).

The Court held that the regulation was valid. As the starting point for its analysis, the Court discussed the broad authority which Congress delegated to the Secretary to promulgate Medicaid eligibility requirements. 101 S.Ct. at

2640. Not only does the complexity of the Social Security Act require deference to the Secretary's regulations, but the Act itself authorizes the Secretary to prescribe regulations which define the income and resources available to a Medicaid applicant. *Id.; see* 42 U.S.C. § 1396a(a)(17)(B). Given this statutory delegation of authority,

> the Secretary's definition of the term "available" is "entitled to more than mere deference or weight." *Batterton* v. *Francis,* 432 U.S., [416] at 426 [97 S.Ct. 2399, 2406, 53 L.Ed.2d 488]. Rather, the Secretary's definition is entitled to "legislative effect" because, "[i]n a situation of this kind, Congress entrusts to the Secretary, rather than to the courts, the primary responsibility for interpreting the statutory term." *Id.,* at 425 [97 S.Ct. at 2405]. Although we do not abdicate review in these circumstances, our task is the limited one of ensuring that the Secretary did not "excee[d] his statutory authority" and that the regulation is not arbitrary or capricious. *Id.,* at 426 [97 S.Ct. at 2406].

101 S.Ct. 2640.
The Court then proceeded to find that the Secretary's regulation was not arbitrary or capricious.

Thus *Gray Panthers* establishes that the Secretary's definition of "available" income and resources cannot be taken lightly. Given the direct conflict in this instance between a federal regulation and Virginia's 1972 transfer of assets rule, the federal regulation controls. *Townsend* v. *Swank,* 404 U.S. 282, 92 S.Ct. 502, 30 L.Ed.2d 448 (1971). Therefore as of January 1, 1972, the transfer rule was invalid and Virginia was not entitled to employ the rule on January 1, 1974, when it chose the § 209(b) option.

The Court is aware that 45 C.F.R. § 248.21(a)(2)(i) created an unfortunate loophole that allows some Medicaid

applicants to become eligible by fraudulently transferring their assets. In light of the *Gray Panther* decision, however, the Court cannot disregard the Secretary's regulations and impose a judicial solution. Congress should provide a remedy, and indeed it has by enacting the Boren-Long Amendment. As the Fourth Circuit noted in *Fabula* v. *Buck,* 598 F.2d 869 (4th Cir. 1979),

> while we sympathize with the state's desire to restrict its medical assistance benefits to those most in need, "a State's interest in preserving the fiscal integrity of its welfare program by economically allocating limited . . . resources may not be protected by the device of adopting eligibility requirements restricting the class of [individuals] made eligible by federal standards."

598 F.2d at 873 (citing *Townsend* v. *Swank,* 404 U.S. at 291, 92 S.Ct. at 507-08).

[4] Defendants nevertheless contend that 45 C.F.R. § 248.21(a)(2)(i) does not apply to a transfer of assets rule. Rather, defendants argue that the regulation merely specifies what resources to count in calculating the income and resources presently held by the applicant and that it does not address a state's effort to prevent fraudulent abuse of Medicaid monies. These are merely semantic distinctions. Regardless of the purpose of a transfer of assets rule, it is an eligibility standard. *Fabula* v. *Buck,* 598 F.2d 869, 873-74 (4th Cir. 1979). The title to 45 C.F.R. § 248.21 is "Financial eligibility—medical assistance programs." The literal language of the regulation leaves no doubt that it applies to all eligibility standards. There is no qualifying language that limits it to "mathematical calculations," as defendants suggest.

[5] Defendants also assert that this issue is moot because the administrative time limits for obtaining reimbursement

for medical care have elapsed, and that injunctive and declaratory relief are of no avail. The Court disagrees. The injunctive relief requested by plaintiffs would merely require defendants to notify the members of the plaintiff class of their possible remedies for obtaining reimbursement from the Commonwealth. As the Supreme Court noted in *Quern* v. *Jordan,* 440 U.S. 332, 349, 99 S.Ct. 1139, 1149, 59 L.Ed.2d 358 (1979), such notice "in effect simply informs class members that their federal suit is at an end that the federal court can provide them with no further relief, and that there are existing state administrative procedures which they may wish to pursue." Whether class members would have to pursue administrative remedies, file a court action, or seek legislative assistance is not relevant to the propriety of notifying plaintiffs of their Medicaid rights. 440 U.S. at 348, n. 20, 99 S.Ct. at 1149, n. 20. These are matters of state law which contain "numerous missing links, which can be supplied, if at all, only by the state and members of the plaintiff class and not by a federal court." *Id.* at 347, 99 S.Ct. at 1148.

Finally, defendant complains of the cost of individual notice to each member of the class. Individual notice is not automatic, however. Rather, it is within the Court's discretion to determine the method of notice "best calculated to reach the aged, blind and disabled class members without imposing an unreasonable burden on the state." *Fabula* v. *Buck,* 598 F.2d 869, 874 (4th Cir. 1979). The Court will determine the appropriate notice only after allowing the parties to present their suggestions on this issue.

For these reasons Virginia's transfer of assets rule, prior to the effective date of the Boren-Long Amendment on July 1, 1981, violates 42 U.S.C. § 1396a(a)(17)(B) and the 1972 regulations implementing § 1396a(a)(17)(B). Sum-

mary judgment against defendants concerning this issue will be granted.

III.

As for the new transfer of assets rule issued by Virginia following enactment of the Boren-Long Amendment, plaintiffs contend that the rule contravenes the requirements of the Amendment in three respects. First, Virginia's rule defines "resources" more narrowly than the SSI transfer rule. In particular the SSI rule exempts a greater amount of property from the transfer of assets rule. *See* 42 U.S.C. § 1382b-(a). Virginia has also chosen to apply its new two-year transfer rule not only to new applications for benefits which were filed after July 1, 1981, but also to redeterminations of a person's eligibility as to claims filed after July 1, 1981. And finally, plaintiffs challenge the administrative regulations issued by Virginia which interpret the "convincing evidence" standard necessary to rebut the presumption of fraud.

A.

[6] As noted previously, the Boren-Long Amendment created a new transfer of assets rule which could be used in both SSI and state Medicaid programs. Section (a) of the Amendment pertains to the SSI transfer rule and provides that any resources transferred within the past 24 months are counted in determining an individual's eligibility, "but subject to the exclusions under [42 U.S.C. § 1382b(a)]." These exclusions specify the resources not taken into account in determining a person's eligibility. 42 U.S.C. § 1382b(a). Section (b) of the Boren-Long Amendment authorizes state Medicaid programs to implement a

transfer of assets rule similar to the SSI rule as long as the state rule uses a "procedure" which is "not more restrictive than the procedure specified" for the SSI rule. Plaintiffs argue that the phrase "not more restrictive than" requires Virginia to use the same resource exclusions as those listed in § 1382b(a).

The key issue is whether the word "procedure" was intended to refer to the SSI exclusions, such that § 209(b) states must incorporate the § 1382b(a) exclusions into their transfer rules.

In interpreting the words of a statute, the Court has "some 'scope for adopting a restricted rather than a literal or usual meaning of its words where acceptance of that meaning would lead to absurd results . . . or would thwart the obvious purpose of the statute' . . . [b]ut it is otherwise 'where no such consequences would follow and where . . . it appears to be consonant with the purposes of the Act. . . .'" *Trans Alaska Pipeline Rate Cases,* 436 U.S. 631, 643, 98 S.Ct. 2053, 2061, 56 L.Ed.2d 591 (1978) (citations omitted). In this instance to accept that the word "procedure" includes the SSI exclusions of § 1382b(a) would lead to absurd results which would thwart the purpose of the Boren-Long Amendment. Therefore the Court finds that Virginia may continue to apply its narrower exclusions in using a transfer rule.

As a § 209(b) state, the Commonwealth has adopted a list of exclusions which is more restrictive than that used by SSI. Va. Manual § 301.1D(2)(a)(1). Virginia uses these exclusions to count the resources available to every Medicaid applicant. These exclusions also apply to resources which have been transferred and are presumed to be available to the applicant. To adopt plaintiffs' reading of the Boren-Long Amendment would require that Virginia

use its § 209(b) exclusions in counting the income and resources actually held in-hand by an applicant, but that it used the broader SSI list of exclusions in applying its transfer of assets rule. This use of two different sets of exclusions leads to a result wholly inconsistent with the purposes of the Boren-Long Amendment.

For instance, Virginia presently considers as an available resource property contiguous to a home; only the home itself is excluded from consideration. The SSI excludes both the home and contiguous property as countable resources. 42 U.S.C. § 1382b(a)(1). If in applying its transfer of assets rule Virginia had to use the § 1382b exclusions, then contiguous property transferred for less than its fair market value before a person applied for Medicaid would not be counted as a resource. If the same applicant had kept that continguous property, however, then at the time of his applying for Medicaid Virginia would use its narrower § 209(b) exclusions, and the contiguous property would then be counted as a resource. Thus there would be an incentive for individuals to transfer contiguous property for less than its fair market value in order to avoid that property from being counted as a resource when they applied for Medicaid.

Such a result directly conflicts with the purpose of the Boren-Long Amendment. As one Congressman stated, the Amendment "is designed to try to discourage people from transferring assets for the purpose of qualifying for these public programs." 126 Cong.Rec. H 12,500 (daily ed. Dec. 13, 1980) (remarks of Rep. Conable). *See also* 126 Cong.Rec. S 16,505-06 (daily ed. Dec. 13, 1980) (remarks of Sen. Long). If Virginia were required to use two different sets of exclusions in counting an applicant's resources, it would be in an applicant's favor for him to transfer those

resources which, though excluded under the broad § 1382b exclusions, would be included by Virginia's policies if he held them until he applied for Medicaid.

Plaintiffs challenge this interpretation of the statute by arguing that the drafters intended to impose a single transfer rule upon every state Medicaid program. They point out that no language in the amendment differentiates between § 209(b) states and SSI states. Plaintiffs also note that the phrase "notwithstanding any other provision of this title" gives precedence to the Amendment over any other conflicting statutory provisions.[4] The Court declines to accept these arguments. Although the Amendment fails to differentiate between § 209(b) states and SSI states, it also suggests no intention to create an incentive for persons to transfer their assets in anticipation of applying for benefits. Planitiffs cannot point to any legislative history of the Amendment which expressly states that the word "procedure" necessarily refers to the § 1382b(a) exclusions. As for the "notwithstanding" language, it sheds little light on how the word "procedure" should be construed.

For these reasons the Court concludes that the Boren-Long Amendment does not require that Virginia use the exclusions of 42 U.S.C. § 1382b(a) in applying its present transfer of assets rule.

B.

[7] Plaintiffs next contest Virginia's new transfer of assets rule on the grounds that it is improperly being applied to applications for benefits and to claims for reimbursement which were filed before July 1, 1981. Section 5(c) of the Boren-Long Amendment states that the SSI transfer of assets rule applies only to applications for benefits filed *after* the effective date of the Amendment. Therefore plaintiffs

reason that Virginia may not now apply its new transfer rule to Medicaid applications filed *before* July 1, 1981, the date on which the Amendment became applicable to the states.[5] In response defendants contend that the Boren-Long Amendment does not address whether Virginia's transfer rule applies to applications filed before July 1, 1981, such that Virginia possesses the discretion to apply its rule in a manner consistent with the purposes of the statute.

With regard to applications for SSI benefits, the Amendment provides that the SSI transfer of assets rule applies only to applications filed after March 1, 1981. Pub.L. No. 96-611, § 5(a), 94 Stat. 3568 (1980). The Secretary has issued regulations which similarly apply the SSI transfer rule to redeterminations of eligibility regarding claims filed after March 1, 1981. *See* 46 Fed. Reg. § 1779 (Oct. 22, 1981), to be *codified at* 20 C.F.R. § 416.1246(f). The Amendment does not explicitly address, however, whether § 209(b) states, in contrast to the SSI policy, may apply their new transfer rules to applications and claims filed before July 1, 1981.

In construing the Boren-Long Amendment, the Court presumes that Congress was aware of other existing provisions of the Social Security Act. *Cannon* v. *University of Chicago,* 441 U.S. 677, 697, 99 S.Ct. 1946, 1958, 60 L.Ed.2d 560 (1979). The Amendment is but one piece of a complex statute, and therefore it should be read in a manner consistent with other pertinent statutory provisions. *Herweg* v. *Ray,* ____ U.S. ____, ____, 102 S.Ct. 1059, 1067, 71 L.Ed.2d 137 (1982).

[8] Transfer of assets rules are elibility standards. *Fabula* v. *Buck,* 598 F.2d 869, 874 (4th Cir. 1979). Therefore a state transfer rule must conform not only to the requirements of the Boren-Long Amendment, but also to other statutory

provisions governing eligibility standards. As a § 209(b) state, Virginia may impose Medicaid eligibility standards which are more restrictive than the SSI standards only if Virginia applied its more restrictive standards as of January 1, 1972. 42 U.S.C. § 1396a(f); 42 C.F.R. § 435.121(b)(1) (1980). In all other cases, Virginia "must provide Medicaid to aged, blind and disabled individuals or couples who receive SSI. . . ." 42 C.F.R. § 435.120 (1980).

Unlike the new SSI transfer of assets rule, Virginia has applied its transfer rule to applications and claims filed before July 1, 1981 "A recipient of Medicaid benefits is ineligible for a specified period of time if he/she improperly transfers [assets] *within two years of the discovery of that transfer*." Va. Manual §§ 301.1(D)(3) and 402.1(B)(3) (1981) (emphasis supplied). Thus, an SSI applicant who filed before March 1, 1981, would not be subject to the transfer restrictions, whereas a Virginia Medicaid applicant who filed before the effective date of the Amendment would be subject to the restrictions. The Virginia rule is therefore more restrictive than the SSI rule. Just as the SSI rule does not apply to applications or claims filed before the effective date of the Boren-Long Amendment, so Virginia may not apply its two-year transfer rule to applications or claims filed before the effective date of July 1, 1981.

There is no indication that by enacting the Boren-Long Amendment Congress intended to give states free reign in designing their own transfer rules only so long as the rules conformed to the language of the Amendment that they be "not more restrictive than the procedure specified" for the SSI rule. Although Senator Long spoke of the Act as giving the states "more flexibility" he was referring only to paragraph 2 of section 5(b), which allows states to lengthen the disqualification period beyond two years in certain in-

stances. *See* 126 Cong.Rec. § 16,505 (daily ed. Dec. 13, 1980). Nothing in the language of the Amendment or in the legislative history suggests that Congress intended to change or alter the applicability of § 1396a(f) and § 1396a (a)(17)(B). Absent such an intent, Virginia may not impose a new transfer of assets rule which is more restrictive than the SSI rule, unless such rule was valid and in use as of January 1, 1972. In this instance the rule did not exist in 1972, and it is more restrictive than its SSI counterpart. Therefore the Commonwealth's present policy of applying the two-year rule to applications and redeterminations filed before July 1, 1981, is invalid.

C.

[9] Plaintiff's third challenge to Virginia's two-year transfer-of-assets rule concerns the Commonwealth's regulations defining the type of "convincing evidence" required to rebut the presumption of fraud. In particular plaintiffs contend that Virginia's interpretation is more restrictive than the corresponding SSI interpretations of "convincing evidence," in violation of 42 U.S.C. § 1396a(j)(1).[6] The pertinent part of the challenged regulation states,

> A subjective statement of intent or ignorance of the property transfer provision is not sufficient [to rebut the presumption of fraud]. The client must provide evidence that other resources were available, at the time of transfer, to meet current and expected needs of that client, including cost of nursing home care.

Va. Manual §§ 301.1(D)(3) and 402.1(B)(3). In response defendants point out that the administrative criteria for the "convincing evidence" standard promulgated by the federal Department of Health and Human Services is as restrictive as the Commonwealth's own criteria.

Assuming that the interpretation of the term "convincing evidence" by a § 209(b) state may not be more restrictive than the criteria applied to SSI applicants, Virginia's interpretation of "convincing evidence" is valid.

The Secretary's regulations implementing the Boren-Long Amendment with regard to SSI applicants state that "[c]onvincing evidence may be pertinent documentary evidence (for example, legal documents, realtor agreements, relevant correspondence, etc.)." 46 Fed.Reg. 51779 (to be codified in 20 C.F.R. § 416.1246(e)). The Department of Health and Human Services has also drafted criteria for its SSI claims manual which establish standards for rebutting the presumption of fraud.[7] The Secretary's regulations and these administrative criteria differ little from Virginia's "convincing evidence" standard. Neither the federal guidelines nor the regulations suggest that a subjective statement of intent is sufficient to rebut the presumption. Rather, they require investigation of the claimant's attempts to dispose of the property at its fair market value, of the alternative means by which the claimant could support himself after the transfer, and of the claimant's relationship to the person who purchased the property. The federal criteria also explicitly refer to documentary evidence as significant rebuttal evidence.

Virginia's policy of not permitting a subjective statement of intent to rebut the presumption is consistent with the Secretary's interpretation. The federal administrative criteria impliedly require more than a subjective statement of intent, because the SSI claims worker must collect much more information than merely the claimant's reason for transferring the property. If a single statement of intent were adequate, there would be little need for this additional information. Similarly, the SSI criteria explicitly require an examination

of a claimant's additional means of supporting himself after the transfer; Virginia's regulations require the same. Thus, Virginia has established policies regarding adequate rebuttal evidence which interpret the phrase "convincing evidence" in a manner consistent with the Secretary's interpretation.

[10] Virginia's interpretation of "convincing evidence" is also justified as a reasonable policy which serves the purposes of the Boren-Long Amendment. The term "convincing" is ambiguous. It could not be used uniformly unless a state agency possessed some discretion to make the term concrete and specific. Unlike the concept of "availability" in 42 U.S.C. § 1396a(a)(17), Congress has not specified that "convincing evidence" must be defined in accordance with regulations promulgated by the Secretary. *Cf. Herweg* v. *Ray*, ____ U.S. ____, ____, 102 S.Ct. 1059, 1066, 71 L.Ed.2d 137 (1982), and *Schweiker* v. *Gray Panthers*, 453 U.S. 1, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981) (Congress' explicit delegation of authority to give substance to a term entitles the Secretary's definition to legislative effect). Therefore, a measure of discretion rests with the Secretary and the states, both of whom bear the joint responsibility of implementing the Boren-Long Amendment, to define "convincing evidence" reasonably and consistently with the purposes of the statute. *New York Dept. of Social Services* v. *Dublino*, 413 U.S. 405, 421-22, 93 S.Ct. 2507, 2516-17, 37 L.Ed.2d 688 (1973). The Court finds that the Commonwealth's policy concerning convincing rebuttal evidence is not only reasonable and consistent with the purposes of the Amendment, but it also is no more restrictive than the Secretary's interpretation of "convincing evidence." Therefore defendants' motion for summary judgment will be granted as to this portion of plaintiff's allegations.

IV.

In accordance with the preceding portions of the opinion, defendants' motion for summary judgment will be granted against plaintiff Randall and the class which she represents. The remainder of defendants' motion will be denied, however, as to the remaining two classes of plaintiffs and summary judgment entered in favor of these classes.

The parties are invited to submit a proposed order granting summary judgment and declaratory and injunctive relief consistent with this opinion within fourteen (14) days of the date of its entry. At that time plaintiffs may also file their proposal for notifying members of the two prevailing plaintiff classes about the court's decision and the procedures by which they may seek retroactive benefits. Within seven (7) days of the filing of plaintiff's proposed notice, defendants may file a response and counter-proposal.

NOTES

[1] As of January 1, 1972, Virginia's transfer of assets rule for Medicaid applicants, as amended, provided that

> An applicant for or recipient of medicaid as a recipient of SSI or a category related to a medically needy individual is ineligible for a period of one year if he transfers or otherwise disposes of his legal or equitable interest in real or personal property within one year prior to application or during receipt of such assistance to become or remain eligible for medicaid. The transfer or disposal of such property to become or remain eligible for SSI is considered as if the transfer or disposal is to become or remain eligible for Medicaid.
>
> Exceptions to this provision are: (1) when property has been transferred that would have no effect on eligibility except a residence when an individual is in a nursing home for a temporary period; (2) when payment has been made approximating the tax value of the property; (3) when payment has been made on the cost of medical care approximating the tax value of the property; or (4) when the property owner has been a victim of actions on the part of another person who for any reason obtained the property without the applicant's/recipient's full understanding of the action.

Virginia State Department of Welfare Medicaid Manual §§ 201. 1A.3(2), 301.1(D)(3), and 402-1(B)(3) (hereafter cited as Va. Manual).

[2] Section 5 of the Boren-Long Amendment states:

> (a) Section 1613 of the Social Security Act is amended by adding at the end thereof the following new subsection:
>
> "Disposal of Resources for Less Than Fair Market Value
>
> "(c)(1) In determining the resources of an individual (and his eligible spouse, if any) there shall be included (but subject to the exclusions under subsection (a)) any resources (or interest therein) owned by such individual or eligible spouse within the preceding 24 months if such individual or eligible spouse gave away or sold such resource or interest at less than fair market value of such resource or interest for the purpose of establishing eligibility for benefits or assistance under this Act.
>
> "(2) Any transaction described in paragraph (1) shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this Act unless such individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.
>
> "(3) For purposes of paragraph (1) the value of such a resource or interest shall be the fair market value of such resource

or interest at the time it was sold or given away, less the amount of compensation received for such resource or interest, if any."

(b) Section 1902 of the Social Security Act is amended by adding at the end thereof the following new subsection:

(j)(1) Notwithstanding any other provision of this title, an individual who *would otherwise be eligible for medical assistance under the State plan approved under this title* may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), *is not more restrictive than the procedure specified in section 1613(c) of this Act.*

"(2) In any case where the uncompensated value of disposed of resources exceeds $12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligibility exceeding 24 months, such plan shall provide for the period of ineligibility to bear a reasonable relationship to such uncompensated value.

"(3) In any case where an individual is ineligible for medical assistance under the State plan solely because of the applicability to such individual of the provisions of section 1613(c), the State plan may provide for the eligibility of such individual for medical assistance under the plan if such individual would be so eligible if the State plan requirements with respect to disposal of resources applicable under paragraphs (1) and (2) of this subsection were applied in lieu of the provisions of section 1613(c)."

(c) The amendment made by subsection (a) [of § 5 of this Act] shall be effective with respect to applications for benefits under title XVI of the Social Security Act filed on or after the first day of the month which begins at least 60 days after the date of enactment of this Act.

Pub. L. No. 96-611, § 5, 94 Stat. 3567 (1980).

[3] The Commonwealth's new transfer rule, effective July 1, 1981, reads as follows:

Property Transfer—Any applicant for medicaid benefits is ineligible for a specified period of time if he/she improperly transfers or otherwise disposes of his/her legal or equitable interest in real or personal property without adequate compensation within two years prior to application for assistance. A recipient of medicaid benefits is ineligible for a specified period of time if he/she improperly transfers or otherwise disposes of his/her legal or

equitable interest in real or personal property within two years of the discovery of that transfer. Such a transfer of property will result in the ineligibility of the assistance unit for two years from the date of transfer if the uncompensated value was $12,000 or less. The period of ineligibility will be increased two months for every $1,000 or part thereof of uncompensated value in excess of $12,000. The amount of the uncompensated value is the fair market value of the property, or the client's interest in the property, established for local tax purposes, less the amount of any compensation received for the property. Exceptions to this provision occur when:

a. A transfer of property as not made in an effort to become or remain eligible for medicaid or SSI. It will be the responsibility of the client to establish that such a transfer was not made in an effort to qualify for medicaid or SSI. The client must provide objective evidence that the transfer was exclusively for another purpose. A subjective statement of intent or ignorance of the property transfer provision is not sufficient.

The client must provide evidence that other resources were available, at the time of transfer, to meet current and expected needs of that client, including cost of nursing home care.

b. Retention of the property would have no effect on eligibility unless the property is a residence of an individual in a nursing home for a temporary period.

c. When the transfer of property resulted in compensation to the client which approximates the equity value of the property. This compensation can be in the form of money, goods or services. The value of goods and services must be reasonable for the community. The value of services provided by a member of the immediate family must be a reasonable rate established prior to receipt of the services.

d. When payment has been made on the cost of medical care which approximates the equity value of the property.

e. Disposition was the result of actions by another person, except a legal guardian or committee, who for any reason obtained the property without the client's full understanding of the action.

f. An improper transfer of property made by a caretaker-relative other than the parent will have no effect on the eligibility of the children.

Va. Manual §§ 301.1(D)(3) and 402.1(B)(3) (1981).

[4] Plaintiffs also cite the decision in *Beltran* v. *Myers*, No. 78-2350 CBM (Mx) (C.D. Cal. July 30, 1981) in support of their position. *Beltran*, however, did not concern a § 209(b) state program. Nor

did the *Beltran* court appear to consider the consequences of imposing the § 1382b(a) exclusions upon a state transfer of assets rule if the state were allowed to use narrower exclusions at other times.

[5] Although March 1, 1981, was the effective date of the Boren-Long Amendment as to the SSI transfer rule, the effective date as to the transfer rule used by state Medicaid transfer rules was July 1, 1981. *Cf.* Pub.L. No. 96-611 §§ 5(c) *with* 2.

[6] Section 5(a) of the Boren-Long Amendment states in part,

> Any transaction [in which property has been sold for less than its fair market value] shall be presumed to have been for the purpose of establishing eligibility for benefits or assistance under this Act unless such individual or eligible spouse furnishes convincing evidence to establish that the transaction was exclusively for some other purpose.

Pub.L. No. 96-611, § 5(a), 94 Stat. 3567 (1980) (codified at 42 U.S.C. § 1382b(c)(2)).

[7] Section A12505.S of the SSI Claims Manual (revised as of October, 1981), provides in part:

> If the claimant wishes to rebut the presumption that resources were transferred for the purpose of establishing SSI eligibility, explain that it will be his/her responsibility to present convincing evidence that the resources were transferred exclusively (i.e., only) for some other reason. Take the claimant's statement concerning the circumstances of the transfer. . . . (If C below applies, this statement is not required.) The statement should cover, but need not be limited to, the following factors:
>
> 1. The claimant's purpose for transferring the resource.
>
> 2. The claimant's attempts to dispose of the resource at FMV.
>
> 3. The claimant's reasons for accepting less than FMV for the resource.
>
> 4. The claimant's means of or plans for supporting himself/herself after the transfer.
>
> 5. The claimant's relationship, if any, to the persons to when the resource was transferred.
>
> 6. The claimant's belief (considering age and background) that fair market value was received.

Request the claimant to submit any pertinent documentary evidence (e.g., legal documents, realtor agreements, relevant correspondence, etc.) Statements on SSA-795's from other individuals may be obtained if material to the decision.

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF VIRGINIA
Charlottesville
Received July 26, 1982
Attorney General, Richmond, Virginia

EVELYN RANDALL, et al,

Plaintiffs,

v.

WILLIAM L. LUKHARD, et al,

Defendants

Civil Action No. 80-50-C

MEMORANDUM OPINION and ORDER

BY: James C. Turk, Chief U. S. District Judge

In accordance with the Memorandum Opinion filed in this action on April 16, 1982, and supplemented by the Memorandum Opinion entered this day, it is hereby

ADJUDGED and ORDERED

that the following three classes of plaintiffs are certified pursuant to Rule 23(b)(2):

CLASS A

All those elderly, blind or disabled persons who (1) applied for Medicaid through the Virginia Medical Assistance Program on or after April 24, 1978, and before July 1, 1981; (2) at the time of their application met all the Medicaid eligibility requirements except the Virginia transfer of assets rule; and (3) were denied Medicaid because of the application of this rule to property which they transferred before July 1, 1979. Plaintiff Morse represents this class.

CLASS B

All those elderly, blind or disabled persons who (1) applied for Medicaid through the Virginia Medical Assistance Program on or after April 24, 1978, and before July 1, 1981; (2) at the time of their application met all the Medicaid eligibility requirements except the Virginia transfer of assets rule; and (3) were denied Medicaid because of the application of this rule to property which they transferred on or after July 1, 1979. Plaintiffs Matthews, Lamb, Smith and Pompey and Rachel Wingo represent this class.

CLASS C

All those elderly, blind or disabled persons who (1) applied for Medicaid through the Virginia Medical Assistance Program on or after July 1, 1981; (2) at the time of their application met all the Medicaid eligibility requirements except the requirements of the Virginia transfer of assets rule; and (3) were denied Medicaid benefits because of the application of the Virginia rule to property which they transferred on or after July 1, 1979. Plaintiff Evelyn Randall represents this class.

Since plaintiffs brought this action under 42 U.S.C. § 1983, the plaintiff classes include only those for whom the two-year statute of limitations had not run as of April 24, 1980, the date on which this action was commenced. *See Wetzel* v. *Liberty Mutual Ins. Co.*, 508 F.2d 239 (3d. Cir.), *cert. denied* 412 U.S. 1011 (1975); 7A Wright & Miller Fd. Prac. & Proc: Civil § 1800 (1972).

It is furthermore

DECLARED and DECREED

that

(1) At all times prior to July 1, 1981, the Commonwealth's transfer of assets rule was invalid under 42 U.S.C.

§ 1396a(F) because, as of January 1, 1972, the rule violated 42 U.S.C. § 1396a(a)(17)(B) and the implementing Federal regulations which governed in 1972 by assuming resources to be available to plaintiffs that were in fact not actually available.

(2) After July 1, 1981, the Commonwealth's transfer of assets policy, revised in light of the Boren-Long Amendment, violated 42 U.S.C. § 1396a(F) and the corresponding federal regulations to the extent that it was applied to persons whose initial application for Medicaid was filed before July 1, 1981.

(3) The Boren-Long Amendment does not, however, require Virginia to use the SSI exclusions of 42 U.S.C. § 1382b(a) in applying its revised transfer of assets rule; and

(4) The Commonwealth's revised transfer of assets rule, and Virginia's regulations implementing the rule, properly define "convincing evidence" in a manner no more restrictive than the corresponding SSI interpretations of "convincing evidence."

According, it is hereby

ADJUDGED and ORDERED

that

(1) Plaintiff's motion for summary judgment is granted in part and denied in part;

(2) Defendants' motion for summary judgment is denied in part, and granted in part.

(3) Defendants, their successors in office, agents, employees, and all other persons in active participation and concert with them, are hereby enjoined from denying Medicaid benefits to the members of plaintiff Classes A and B on the grounds that such persons transfer resources for less than fair market value.

(4) Defendants will provide plaintiffs Morse, Matthews, Lamb, Smith, and Pompey and Rachel Wingo:

(a) Immediate reinstatement of Medicaid eligibility, provided they presently meet the other eligibility requirements that are unrelated to the transfer of assets rule.

(b) The opportunity to present to the appropriate local office of the Virginia Department of Welfare evidence of their incurred medical expenses (whether paid or not), which, but for application of the transfer rule, would have been paid for under the Virginia Medicaid program.

(c) Access to the Virginia Medicaid program's administrative process, or to any other appropriate state administrative or judicial process, if there are disputes as to whether and how much money they should be paid or reimbursed.

(5) Defendants will determine the identity of all members of Plaintiff Class A and B and will cause to be reinstated onto Medicaid coverage all of these persons who are presently otherwise eligible for Medicaid.

(a) The reinstatement of Medicaid coverage to these members of the two classes will be completed within 90 days of the date of this Order.

(b) Within 60 days after the reinstatement process has been completed, Defendants will file with this Court a certificate setting forth the names, addresses and date of disqualification of each person so reinstated.

(6) In addition to identifying and reinstating the members of plaintiff Classes A and B, defendants will also notify every member of these classes that he or she may be eligible for reimbursement for medical bills incurred during his or her period of disqualification.

(a) Defendants will send, by first-class mail, a copy of the notice (attached hereto as Appendix "A") and a copy of the notice of appeal form (attached hereto as Appendix "B") to each class member.

(b) This mailing will be accomplished by the Defendants within 120 days of the date of this Order.

(c) Within 60 days from the date upon which this mailing is completed, Defendants will file with this Court a certificate setting forth the names, addresses and date of disqualification of all persons and estates so notified.

(7) In addition to the sending of individual notices as outlined above, Defendants will send notice of the Court's decision in the case to every hospital, nursing home, or other medical or treatment facility in the State of Virginia which has at any time since the transfer rule was enacted had a Medicaid Provider Reimbursement Agreement with the State. The notice will advise the hospitals that individuals previously denied Medicaid pursuant to the transfer rule may re-apply for Medicaid and also apply to the Medicaid program for possible reimbursement. It will also give the name, address and telephone number of counsel for Plaintiffs and advise the hospitals that they may contact counsel if they have any questions about the case.

(a) This mailing will be accomplished by the Defendants within 120 days of the date of this Order.

(b) Within 60 days from the date upon which this mailing is completed, Defendants will file with this Court a copy of the notice sent, together with a certificate setting forth the names and addresses of all medical facilities notified.

(8) Attorney's fees will be awarded after this order has become final upon appeal or upon the lapse of time in which to appeal this order.

The parties in this action have requested that the Court clarify its decision of April 16, 1982, with regard to whether the Boren-Long Amendment to the Social Security Act, Pub. L. No. 96-611, § 5, 94 Stat. 3567 (1980), permits § 209(b) states such as Virginia to apply the two-year transfer of

assets rule to individuals whose applications for Medicaid benefits were filed prior to the effective date of the Boren-Long Amendment, July 1, 1981.

Defendants contend that the Boren-Long Amendment does not operate as a grandfather clause that precludes persons whose applications had been filed prior to July 1, 1981, from being subject to the Boren-Long transfer of assets rule. Defendants instead assert that the Court's previous opinion interpreted the Amendment narrowly. Noting that 42 U.S.C. § 1396a(a)(34) allows an applicant to be reimbursed for medical services received within the three months prior to his application, defendants suggest that the Court's April 16 opinion merely prohibited the Commonwealth from using the two-year transfer rule to deny those claims filed under § 1396a(a)(34) prior to July 1, 1981. This interpretation would permit Virginia to use the new two-year transfer rule not only to determine the initial eligibility of those persons who filed applications after July 1, 1981, but also to redetermine the eligibility of those persons who filed before July 1, 1981.

As a § 209(b) state, Virginia may impose Medicaid eligibility standards which are more restrictive than the SSI standards only if these more restrictive standards were valid and were in use as of January 1, 1972. 42 U.S.C. § 1396a(f); 42 C.F.R. §§ 435.121(b) and 435.845(e). The Boren-Long Amendment expressly stated that the two-year transfer rule for SSI would not apply to individuals who had filed applications prior to the SSI effective date of March 1, 1981. Pub. L. No. 96-611, § 5(c), 94 Stat. 3567 (1980); *see also* 46 Fed. Reg. 1779 (Oct. 22, 1981), *to be codified at* 20 C.F.R. § 416.1246(f). The Amendment did not, however, state when § 209(b) states could begin applying the two-year transfer rule. The issue presently before

the Court thus concerns whether § 209(b) states must follow 42 U.S.C. § 1396a(f) and the corresponding regulations which require that the states' eligibility requirements be no more restrictive than the SSI requirements, or whether Congress, in passing the Boren-Long Amendment, granted states the discretion to deviate from the SSI rule and apply the transfer rule to all Medicaid recipients after July 1, 1981, regardless of when the recipients filed their applications.

Despite defendants' interpretation, the Court concludes that the Boren-Long Amendment, when read in conjunction with the other provisions of the Social Security Act, precludes the application of the two-year transfer of assets rule to individuals whose applications for Medicaid benefits were filed before July 1, 1981. The Boren-Long Amendment does not completely define the parameters of Virginia's transfer of assets rule; rather, the Amendment must be read in conjunction with the Social Security Act as a whole. *See Herweg* v. *Ray*, 102 S.Ct. 1059, 1067 (1982). As noted previously, the Secretary's regulations require that, unless in use as of January 1, 1972, a state eligibility requirement may not be more restrictive than the corresponding SSI eligibility requirements. Thus, just as the SSI may not apply the two-year transfer rule to individuals who filed applications before March 1, 1981, so § 209(b) states may not apply their two-year transfer rules to applications filed before the Amendment's effective date of July 1, 1981. To hold otherwise would allow Virginia to apply an eligibility requirement more restrictive than that of the SSI, since state Medicaid applicants who filed before the amendment's effective date would be subject to the transfer rule, but SSI applicants who filed before the effective date would not be subject to the rule.

Defendants argue, however, that Congress had no in-

tention of creating a "grandfathered" class of Medicaid recipients. Congress nevertheless, explicitly created a grandfathered class of SSI recipients. Given that the Court is required to presume that Congress was aware of other provisions of the Social Security Act which require Medicaid eligibility requirements to be no more restrictive than the SSI requirement, the Court must also then presume that Congress intended to treat Medicaid recipients the same as SSI recipients. *See Cannon* v. *University of Chicago*, 441 U.S. 677, 697 (1979). The legislative history of the Boren-Long Amendment supports this conclusion that the states were to develop transfer of assets rules which were very similar to the SSI rule. As Senator Long stated,

> The amendment would permit states to establish disposal of asset disqualification rules for medical purposes which differ in detail from the SSI rule. Generally, state rules could not be more restrictive than the Federal SSI rule except that the period of disqualification could be longer [in certain instances]. . . .

126 Cong. Rec. § 16, 505-06 (daily ed. Dec. 13, 1980) (remarks of Sen. Long). To permit states to treat Medicaid applicants differently than SSI applicants by applying the transfer rule to applications filed before the effective date of July 1, 1981, is a significant difference, rather than a mere change "in detail." Senator Long's remarks further indicate that State rules may differ from the SSI rule in one respect only. Finally, neither the language of the statute nor the legislative history reveal an intent to create an exception to 42 U.S.C. § 1396a(f) and the Secretary regulations, so as to allow Virginia to use a more restrictive eligibility requirement in this particular instance.

The legislative history also suggests that the transfer rule is to be applied prospectively only and not used to remove

from the Medicaid rolls persons who have already been found to be eligible under different standards. Senator Long referred to persons "*applying* for SSI benefits." *Id.* at 516, 505 (emphasis supplied). And a representative noted that the amendment "provides that if there is an exchange of asset for the purpose of *getting on welfare,* there will be a two-year delay in those payments." *Id.* at H 12,500 (remarks of Rep. Ullman) (emphasis supplied). Although these may be rather thin threads amidst a threadbare legislative history, it appears that Congress contemplated applying the new transfer rule only to those who had not yet applied for and were not yet receiving benefits.

Yet defendants contend that to construe the Boren-Long Amendment in this fashion violates the requirement in 42 U.S.C. § 1396a(a)(17) that a State's Medicaid plan "include reasonable standards . . . which shall be comparable for all groups. . . ." To exempt those Medicaid applicants who filed before July 1, 1981, defendants allege, would create a double standard for groups of Medicaid recipients: some would be subject to the two-year transfer of assets rule, others would not, therefore the standards for all groups are not comparable. The Court's interpretation of the Boren-Long Amendment may indeed have this effect, and thus perhaps conflict with the comparability requirement of § 1396a(a)(17). "Comparable between all groups" does not, however, require that all members of a particular group be treated alike when Congress appears to have intended that some group members be treated differently than others. Section 1396a(a)(17) refers to eligibility standards *between* SSI groups, not to standards *within* a particular group which were mandated by a change in the Social Security Act. In sum, for the reasons set forth above, Congress expressed a specific concern for exempting certain individuals

from the two-year transfer rule, and in the absence of any mention of creating an exception to 42 U.S.C. § 1396a(f) and the Secretary's accompanying regulation, the Court concludes that Congress nevertheless intended to preclude states from applying the transfer rule to persons who filed applications before July 1, 1981.

DATED: This 22nd day of July, 1982.

JAMES C. TURK
Chief U. S. District Judge

A TRUE COPY, TESTE:
JOYCE F. WITT, *Clerk*

By: V. HARRIS,
Deputy Clerk

APPENDIX A

IMPORTANT NOTICE

YOU MAY BE ELIGIBLE TO BE REIMBURSED FOR MEDICAL COSTS THAT WERE PAID OR ARE OWED FOR NECESSARY HEALTH CARE WHICH SHOULD HAVE BEEN PAID FOR BY MEDICAID.

Before July 1, 1981, Virginia had a rule—known as a "transfer of assets" rule—by which state officials denied Medicaid eligibility to people who had transferred or given away property before applying for Medicaid. Our records indicate that you may be one of those people.

A federal court in Charlottesville, Virginia, has recently declared that state rule invalid. THE COURT ORDERED THE STATE TO TELL PEOPLE WHO WERE DENIED MEDICAID BECAUSE OF THIS RULE THAT THEY MAY BE ABLE TO RECOVER MONEY SPENT OR OWED IN THE PAST FOR WHICH MEDICAID WOULD HAVE PAID FOR. If you have ever been denied Medicaid because you transferred, sold or gave away property to someone else, there are steps you can take which might allow you to be reimbursed for the bills you incurred during the time when the state said you were ineligible for Medicaid. You might be eligible to recover these past amounts *even if you are now eligible for and receiving Medicaid*.

In accordance with the court's order, the Virginia Department of Welfare is obligated to redetermine whether you would have been eligible for Medicaid if the state had not been using the "transfer of assets" rule. In order to determine what amount, if any, you (or your doctor, pharmacist, nursing home, etc.) are entitled to, you should contact your

local welfare or social services office and arrange for a new determination of your past eligibility. You or your representative should be prepared to bring any records which would indicate the nature and amount of medical expenses which you, your relatives or friends may have incurred as a result of the state previously denying your application.

If you are dissatisfied with the new determination, either because the state says that you were still ineligible for that period or because the state decides to repay you less than the amount you think right, you will have an opportunity to seek a fair hearing and to otherwise challenge the state's decision, just as you would in any other situation where the state decides against you.

Although you are under no obligation to take any action in response to this letter, *it is to your benefit to do so.* You may be eligible to be reimbursed for bills you have already paid, or to have outstanding bills paid for by Medicaid.

We have enclosed with this notice an appeal form. If you wish to file an appeal to try to get the State Medicaid program to pay for any past medical expenses, you should fill out this form and mail it to the address on the form.

If you have any questions about this letter and the procedure it discusses, you should contact your attorney or the nearest legal aid office or your local welfare or social services office.

WILLIAM LUKHARD, *Director*
Virginia Department of Welfare

APPENDIX B

COMMONWEALTH OF VIRGINIA

Appeal to Medical Assistance Appeals Board

MAIL TO:
Health Department
Medical Assistance Program
109 Governor Street
Richmond, Virginia 23219

(This notice is sent as part of the order of the U.S. District Court for the Western District of Virginia in the case of *Randall* v. *Lukhard*, dealing with the Medicaid transfer of assets rule.)

Pursuant to the provisions of the Virginia Medical Assistance Program, I, _____
(First Name) (Middle Name) (Last Name)

_____,
(Address)

_____ do hereby appeal for a
(Medical Assistance ID No.)

review of the action of the _____

_____
(Agency or Medical Provider name and address)

The Public Welfare Agency:

__Refused to take my application for medical assistance.

__Failed to determine my eligibility for medical assistance within thirty days (or sixty days if disability) after application which was made on _____
Month Day Year

__Declared me ineligible for medical assistance.

__Cancelled my eligibility for medical assistance.

__Other action which affected receipt of medical assistance.

The date of action was _____. I received the written notification on _____.

The Medical Provider or the State Health Department because of its policies:

__Denied me covered medical services.

__Delayed my receipt of covered medical services.

__Other action which affected receipt of medical assistance.

I believe I am eligible for a fair hearing because: _____

_____

_____

_____

_____ Signed: _____

(Date) (Appellant)

APPENDIX C

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

No. 82-1773

EVELYN RANDALL, et al,

Appellees,

v.

WILLIAM L. LUKHARD, etc., et al,

Appellants,

and

RICHARD SCHWEIKER, etc.,

Amicus Curiae.

No. 82-1774

EVELYN RANDALL, et al,

Appellants,

v.

WILLIAM L. LUKHARD, etc., et al,

Appellees,

and

RICHARD SCHWEIKER, etc.,

Defendant.

Appeals from the United States District Court for the Western District of Virginia, at Charlottesville. James C. Turk, District Judge.

The defendants/appellants' petition for rehearing and suggestion for rehearing in banc has been submitted to the court. A poll of the court was requested and in the poll Judges Russell, Widener, Hall, Murnaghan, and Chapman voted to grant rehearing in banc, and Chief Judge Winter, Judges Phillips, Sprouse, and Ervin voted to deny rehearing in banc. A majority of the judges eligible to vote, having voted to grant rehearing in banc,

IT IS ORDERED that rehearing in banc is granted.

For the Court—by Direction

WILLIAM K. SLATE, II
Clerk

Filed September 1, 1983 U.S. Court of Appeals
Fourth Circuit

UNITED STATES COURT OF APPEALS

FOR THE FOURTH CIRCUIT

No. 82-1773

Filed Apr. 2, 1984 U.S. Court of Appeals
Fourth Circuit

EVELYN RANDALL, et al,

Appellees,

v.

WILLIAM L. LUKHARD, etc., et al,

Appellants,

and

RICHARD SCHWEIKER, etc.,

Amicus Curiae,

GRAY PANTHERS,

Amicus Curiae.

No. 82-1774

EVELYN RANDALL, et al,

Appellants,

v.

WILLIAM L. LUKHARD, etc., et al,

Appellees,

and

RICHARD SCHWEIKER,

Defendant,

GRAY PANTHERS,

Amicus Curiae.

Appeals from the United States District Court for the Western District of Virginia, at Charlottesville. James C. Turk, District Judge

---

Upon consideration of appellants' motion for stay of mandate;

IT IS ORDERED that the mandate of this court is stayed pending application for a writ of certiorari.

Entered at the direction of Chief Judge Winter for the court.

For the Court,

WILLIAM K. SLATE, II
Clerk

APPENDIX D

CONSTITUTION OF THE UNITED STATES

[AMENDMENT XI]

[*Restriction of Judicial Power*]

The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state, or by citizens or subjects of any foreign state.

42 U.S.C. § 1396a(a)

A State plan for medical assistance must—

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., 1381 et seq., or 601 et seq.], and with respect to whom supplemental security income benefits are not being paid under title XVI [42 USCS §§ 1381 et seq.], based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this title [42 USCS §§ 1396-1396d, 1396f-1396i], (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV [42 USCS §§ 301 et seq., 1201 et seq., 1351 et seq., or 1381 et seq., or 601 et seq.], or to have paid with respect to him supplemental security income benefits under title XVI [42 USCS §§ 1381 et seq.]) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits. (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under

the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under 21 or (with respect to States eligible to participate in the State program established under title XVI [42 USCS §§ 1381 et seq.]), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 [42 USCS § 1382c] (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the cost (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

42 U.S.C. § 1396a

(f) Duty of State to provide medical assistance as determined by effective date of State plan. Notwithstanding any other provision of this title [42 USCS §§ 1396-1396d, 1396f-1396i], except as provided in subsection (e), no State not eligible to participate in the State plan program established under title XVI [42 USCS §§ 1381 et seq.] shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of title XVI [42 USCS §§ 1381-1383c]) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this title [42 USCS §§ 1396-1396d, 1396f-1396i] and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1903(f) [42 USCS § 1396b(f)] (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual), and incurred expenses for medical case as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10)(C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection if that individual is, or is eligible to be (1) an individual with

respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10)(A), or (2) an eligible individual or eligible spouse, as defined in title XVI, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10)(C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10)(C) of that subsection, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10)(A) of that subsection.

45 CFR § 248.21 (1972)

(a) State plan requirements. A State plan under title XIX of the Social Security Act must:

* * *

(2) With respect to both the categorically needy and, if they are included in the plan, the medically needy:

(i) Provide that only such income and resources as are actually available will be considered and that income and resources will be reasonably evaluated;

(ii) Provide that financial responsibility of any individual for any applicant or recipient of medical assistance will be limited to the responsibility of spouse for spouse and of parents for children under age 21, or blind, or permanently and totally disabled;

(iii) Specify the extent to which the financial responsibility of any such relatives is taken into account.

(3) With respect to the medically needy, if they are included in the plan:

* * *

(d) Resources which may be held must, as a minimum, be at the most liberal level used in any money payment program in the State on or after January 1, 1966, and the amount of liquid assets which may be held must increase with an increase in the number of individuals in the family. There must be separate levels established for resources.

(ii) Provide that there will be a flexible measurement of available income which will be applied in the following order of priority. . . .

Subpart E—Fair Hearings for Applicants and Recipients

SOURCE: 44 FR 17932, Mar. 29, 1979, unless otherwise noted.

GENERAL PROVISIONS

§ 431.200 Basis and purpose.

This subpart implements section 1902(a)(3) of the Act, which requires that a State plan provide an opportunity for a fair hearing to any person whose claim for assistance is denied or not acted upon promptly. This subpart also prescribes procedures for an opportunity for hearing if the Medicaid agency takes action to suspend, terminate or reduce services.

§ 431.201 Definitions.

For purposes of this subpart:

"Action" means a termination, suspension, or reduction of Medicaid eligibility or covered services.

"Date of action" means the intended date on which a termination, suspension, or reduction becomes effective.

"De novo hearing" means a hearing that starts over from the beginning.

"Evidentiary hearing" means a hearing conducted so that evidence may be presented.

"Notice" means a written statement that meets the requirements of § 431.210.

"Request for a hearing" means a clear expression by the applicant or recipient, or his authorized representative, that he wants the opportunity to present his case to a reviewing authority.

§ 431.202 State plan requirements.

A State plan must provide that the requirements of *§§ 431.205 through 431.246 of this subpart* are met.

§ 431.205 Provision of hearing system.

(a) The Medicaid agency must be responsible for maintaining a hearing system that meets the requirements of this subpart.

(b) The State's hearing system must provide for—

(1) A hearing before the agency; or

(2) An evidentiary hearing at the local level, with a right of appeal to a State agency hearing.

(c) The agency may offer local hearings in some political subdivisions and not in others.

(d) The hearing system must meet the due process standards set forth in *Goldberg* v. *Kelly*, 397 U.S. 245 (1970), and any additional standards specified in this subpart.

§ 431.206 Informing applicants and recipients.

(a) The agency must issue and publicize its hearing procedures.

(b) The agency must, at the time specified in paragraph (c) of this section, inform every applicant or recipient in writing—

(1) Of his right to a hearing;

(2) Of the method by which he may obtain a hearing; and

(3) That he may represent himself or use legal counsel, a relative, a friend, or other spokesman.

(c) The agency must provide the information required in paragraph (b) of this section—

(1) At the time that the individual applies for Medicaid; and

(2) At the time of any action affecting his claim.

NOTICE

§ 431.210 Content of notice.

A notice required under § 431.206(c)(2) of this subpart must contain—

(a) A statement of what action the agency intends to take;

(b) The reasons for the intended action;

(c) The specific regulations that support, or the change in Federal or State law that requires, the action;

(d) An explanation of—

(1) The individual's right to request an evidentiary hearing if one is available, or a State agency hearing; or

(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and

(e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

§ 431.211 Advance notice.

The State or local agency must mail a notice at least 10 days before the date of action, except as permitted under §§ 431.213 and 431.214 of this subpart.

§ 431.213 Exceptions from advance notice.

The agency may mail a notice not later than the date of action if—

(a) The agency has factual information confirming the death of a recipient;

(b) The agency receives a clear written statement signed by a recipient that—

(1) He no longer wishes services; or

(2) Gives information that requires termination or reduction of services and indicates that he understands that this must be the result of supplying that information;

(c) The recipient has been admitted to an institution where he is ineligible under the plan for further services;

(d) The recipient's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See § 431.231 (d) of this subpart for procedure if the recipient's whereabouts become known);

(e) The agency establishes the fact that the recipient has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth; or

(f) A change in the level of medical care is prescribed by the recipient's physician.

§ 431.214 Notice in cases of probable fraud.

The agency may shorten the period of advance notice to 5 days before the date of action if—

(a) The agency has facts indicating that action should be taken because of probable fraud by the recipient; and

(b) The facts have been verified, if possible, through secondary sources.

Right to Hearing

§ 431.220 When a hearing is required.

(a) The agency must grant an opportunity for a hearing to:

(1) Any applicant who requests it because his claim for services is denied or is not acted upon with reasonable promptness; and

(2) Any recipient who requests it because he believes the agency has taken an action erroneously.

(b) The agency need not grant a hearing if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients.

§ 431.221 Request for hearing.

(a) The agency may require that a request for a hearing be in writing.

(b) The agency may not limit or interfere with the applicant's or recipient's freedom to make a request for a hearing.

(c) The agency may assist the applicant or recipient in submitting and processing his request.

(d) The agency must allow the applicant or recipient a reasonable time, not to exceed 90 days from the date that notice of action is mailed, to request a hearings.

§ 431.222 Group hearings.

The agency—

(a) May respond to a series of individual requests for hearing by conducting a single group hearing;

(b) May consolidate hearings only in cases in which the sole issue involved is one of Federal or State law or policy;

(c) Must follow the policies of this subpart and its own policies governing hearings in all group hearings; and

(d) Must permit each person to present his own case or be represented by his authorized representative.

§ 431.223 Denial or dismissal of request for a hearing.

The agency may deny or dismiss a request for a hearing if—

(a) The applicant or recipient withdraws the request in writing; or

(b) The applicant or recipient fails to appear at a scheduled hearing without good cause.

PROCEDURES

§ 431.230 Maintaining services.

(a) If the agency mails the 10-day or 5-day notice as required under § 431.211 or § 431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision.

(b) If the agency's action is sustained by the hearing decision, the agency may institute recovery procedures against the applicant or recipient to recoup the cost of any services furnished the recipient, to the extent they were furnished solely by reason of this section.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980]

§ 431.231 Reinstatement of services.

(a) The agency may reinstate services if a recipient requests a hearing not more than 10 days after the date of action.

(b) The reinstated services must continue until a hearing decision unless, at the hearing, it is determined that the sole issue is one of Federal or State law or policy.

(c) The agency must reinstate and continue services until a decision is rendered after a hearing if—

(1) Action is taken without the advance notice required under § 431.211 or § 431.214 of this subpart;

(2) The recipient requests a hearing within 10 days of the mailing of the notice of action; and

(3) The agency determines that the action resulted from other than the application of Federal or State law or policy.

(d) If a recipient's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to him, any discontinued services must be reinstated if his whereabouts become known during the time he is eligible for services.

§ 431.232 Adverse decision of local evidentiary hearing.

If the decision of a local evidentiary hearing is adverse to the applicant or recipient, the agency must—

(a) Inform the applicant or recipient of the decision;

(b) Inform the applicant or recipient that he has the right to appeal the decision to the State agency, in writing, within 15 days of the mailing of the notice of the adverse decision;

(c) Inform the applicant or recipient of his right to request that his appeal be a *de novo* hearing; and

(d) Discontinue services after the adverse decision.

§ 431.233 State agency hearing after adverse decision of local evidentiary hearing.

(a) Unless the applicant or recipient specifically requests a *de novo* hearing, the State agency hearing may consist of a review by the agency hearing officer of the record of the local evidentiary hearing to determine whether the decision

of the local hearing officer was supported by substantial evidence in the record.

(b) A person who participates in the local decision being appealed may not participate in the State agency hearing decision.

§ 431.240 Conducting the hearing.

(a) All hearings must be conducted—

(1) At a reasonable time, date, and place;

(2) Only after adequate written notice of the hearing; and

(3) By one or more impartial officials or other individuals who have not been directly involved in the initial determination of the action in question.

(b) If the hearing involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision, and if the hearing officer considers it necessary to have a medical assessment other than that of the individual involved in making the original decision, such a medical assessment must be obtained at agency expense and made part of the record.

§ 431.241 Matters to be considered at the hearing.

The hearing must cover—

(a) Agency action or failure to act with reasonable promptness on a claim for services, including both initial and subsequent decisions regarding eligibility; and

(b) Agency decisions regarding changes in the type or amount of services.

§ 431.242 Procedural rights of the applicant or recipient.

The applicant or recipient, or his representative, must be given an opportunity to—

(a) Examine at a reasonable time before the date of the hearing and during the hearing:

(1) The content of the applicant's or recipient's case file; and

(2) All documents and records to be used by the State or local agency at the hearing;

(b) Bring witnesses;

(c) Establish all pertinent facts and circumstances;

(d) Present an argument without undue interference; and

(e) Question or refute any testimony or evidence, including opportunity to confront and cross-examine adverse witnesses.

§ 431.243 Parties in cases involving an eligibility determination.

If the hearing involves an issue of eligibility and the Medicaid agency is not responsible for eligibility determinations, the agency that is responsible for determining eligibility must participate in the hearing.

§ 431.244 Hearing decisions.

(a) Hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing.

(b) The record must consist only of--

(1) The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;

(2) All papers and requests filed in the proceeding; and

(3) The recommendation or decision of the hearing officer.

(c) The applicant or recipient must have access to the record at a convenient place and time.

(d) In any evidentiary hearing, the decision must be a written one that—

(1) Summarizes the facts; and

(2) Identifies the regulations supporting the decision.

(e) In a *de novo* hearing, the decision must—

(1) Specify the reasons for the decision; and

(2) Identify the supporting evidence and regulations.

(f) The agency must take final administrative action within 90 days from the date of the request for a hearing.

(g) The public must have access to all agency hearing decisions, subject to the requirements of Subpart F of this part for safeguarding of information.

§ 431.245 Notifying the applicant or recipient of a State agency decision.

The agency must notify the applicant or recipient in writing of—

(a) The decision; and

(b) His right to request a State agency hearing or seek judicial review, to the extent that either is available to him.

§ 431.246 Corrective action.

The agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, if—

(a) The hearing decision is favorable to the applicant or recipient; or

(b) The agency decides in the applicant's or recipient's favor before the hearing.

Federal Financial Participation

§ 431.250 Federal financial participation.

FFP is available in expenditures for—

(a) Payments for services continued pending a hearing decision;

(b) Payments made—

(1) To carry out hearing decisions; and

(2) For services provided within the scope of the Federal Medicaid program and made under a court order.

(c) Payments made to take corrective action prior to a hearing;

(d) Payments made to extend the benefit of a hearing decision or court order to individuals in the same situation as those directly affected by the decision or order;

(e) Retroactive payments under paragraphs (b), (c), and (d) of this section in accordance with applicable Federal policies on corrective payments; and

(f) Administrative costs incurred by the agency for—

(1) Transportation for the applicant or recipient, his representative, and witnesses to and from the hearing;

(2) Meeting other expenses of the applicant or recipient in connection with the hearing; and

(3) Carrying out the hearing procedures, including expenses of obtaining the additional medical assessment specified in § 431.240 of this subpart.

[44 FR 17932, Mar. 29, 1979, as amended at 45 FR 24882, Apr. 11, 1980]

3. *Property Transfer*—An applicant for or recipient of Medicaid as a recipient of SSI or a category-related medically needy individual is ineligible for a period of one year if he transfers or otherwise disposes of his legal or equitable interest in real or personal property within one year prior to application or during receipt of such assistance to become or remain eligible for Medicaid. Transfer or disposal of such property to become or remain eligible for SSI is considered as if the transfer or disposal is to become or remain eligible for Medicaid.

Exceptions to this provision are: (1) when property has been transferred that would have no effect on eligibility except a residence when an individual is in a nursing home for a temporary period; (2) when payment has been made approximating the tax value of the property; (3) when payment has been made on the cost of medical care approximating the tax value of the property; or (4) when the property owner has been a victim of actions on the part of another person who for any reason obtained property without the applicant's/recipient's full understanding of the action.

STATE PLAN UNDER TITLE XIX OF THE
SOCIAL SECURITY ACT
STATE OF VIRGINIA

3. *Property Transfer*—An applicant for or recipient of Medicaid as a recipient of SSI or a category-related medically needy individuai is ineligible if he within one year prior to application or during the receipt of such assistance, transfers or otherwise disposes of his legal or equitable interest in real or personal property when Medicaid eligibility would not have existed had the property been retained.

Exceptions to this provision may exist when there has been a disposition of resources and payment has been made which approximate the fair cash market value of the property, or transfer or disposition was essential due to incurred obligations for necessities such as shelter, food, and medical care. Disposition of property may not in itself be a bar to eligibility, if there is sufficient evidence that such disposition was for a justifiable reason.

AFFIDAVIT

I, I. Guy Lusk, after being duly sworn, do upon oath say as follows:

1) that I am employed by the Virginia Department of Social Services as the Director of the Division of Benefit Programs;

2) that one of my primary responsibilities is to oversee the eligibility determination process for the Virginia Medical Assistance Plan (i.e. Medicaid Program) by Virginia's 124 local departments of welfare/social services;

3) that I have reviewed the July 22, 1982, Memorandum Opinion and Order entered by Judge James C. Turk, Chief Judge, United States District Court for the Western District of Virginia in the matter of *Evelyn Randall, et al.* v. *William L. Lukhard, et al.*, Civil Action No. 80-50 (C);

4) that in order to implement all aspects of that Order, the state defendants would not be able to review local board action forms in all agencies to determine which individuals should be contacted because there is no mandated statewide use of any such forms for medicaid;

5) that no Research and Reporting ("R & R") forms which are completed by the 124 local departments on a monthly basis would provide the necessary information to determine whether any individuals would have to be contacted;

6) that in order to correctly implement the requirements of the above referenced court order, it will therefore be necessary to review each currently active "medicaid-only" case, which, as of March, 1982, numbered 99,962 cases;

7) that each local agency is required to keep individual case records for a period of five years from the date in which the case was closed for any reason and it would be necessary

therefore to review all inactive "medicaid-only" cases which were denied or cancelled (i.e. terminated) during that five-year period.

8) that the number of "medicaid-only" cases closed over the last five years for any reason was 331,304;

9) of that number, 182,158 "medicaid-only" cases were denied or cancelled during the time period for which the court has ordered relief (i.e. April 29, 1978, to June 30, 1981);

10) that based on caseload standards developed in the normal course of business by the State Department of Social Services for the allocation of staff resources within each local agency, it is estimated that it would require at least 15,064 man hours to identify each of the "medicaid-only" cases potentially affected by the Court Order at a cost of $164,510 to the State Defendants.

11) that based on the Department of Social Services Quality Control statistics, it is estimated that there may have been as many as 853 cases denied or terminated between April 24, 1978, and June 30, 1981, because of the transfer of assets rule;

12) that a notice and package of instructions would have to be developed for mailing to any identified case for which a current address exists describing the Court's Order, and the process to be followed to re-apply for benefits at a cost of at least $5,806.

13) that a routine application form would also have to be included with the notice;

14) that based on the above-described caseload standards, the processing of all applications received would take, on the average, 1.81 hours per case at a cost to the State Defendants of $19.65 per application.

15) that, for every application found to be eligible, it

would have to be enrolled and made part of the current recipient eligibility file.

GUY LUSK, *Director*
Division of Benefit Programs

Sworn to and subscribed before me this 29th day of July, 1982, in my jurisdiction.

PHYLLIS J. SISK
Notary

My commission expires: Oct. 28, 1983.

AFFIDAVIT

Ann E. Cook, being duly sworn, deposes and says as follows:

1) I am Ann E. Cook, the Acting Director of the Division of Medical Social Services of the Office of Medical Assistance in the State Health Department of the Commonwealth of Virginia. I have been employed in the Virginia Medical Assistance Program since April 16, 1975, and I am familiar with matters concerning medicaid eligibility and program administration. I am the same Ann E. Cook who has submitted other affidavits and responses to discovery requests in *Randall* v. *Lukhard,* Civil Action No. 80-50(c).

2) I have read the order of the Court in the above-styled action, dated July 22, 1982. As a result, I have come to certain conclusions as to what would be required to comply with the court's order.

3) Once the state defendants have identified the persons who were denied medicaid benefits or who had medical benefits terminated due to the former transfer-of-assets rule between April 24, 1978 and July 1, 1981, the state defendants are required by the court's order to notify every member of the two plaintiff classes that he or she may be eligible for reimbursement for medical bills incurred during his or her period of disqualification. This mailing must be completed within 120 days of the court's July 22, 1982, order. The costs involved in preparing and duplicating the notice and the cost of mailing the notice cannot be reliably established at this time, but in the past, mailings to recipients, notifying them of reductions in the level of benefits has cost thousands of dollars. There is no routine or regular mailing of information to the members of the two plaintiff classes that could be used to minimize the expense. More-

over, because such a mailing is not routine, it will be unusually burdensome to the staff of the Virginia Medical Assistance Program because it is an unanticipated responsibility.

4) Following this mailing, the court's order requires the State defendants to redetermine the past medicaid eligibility of each person who responds to the notice. The Program's eligibility requirements, however, have not been static for the last five years. Changes in medicaid eligibility have occurred at least quarterly in this time period, and, therefore, for each person responding to the notice, the eligibility case worker would have to reconstruct the eligibility requirements in effect when each medical expense was incurred. Reconstruction of the eligibility requirements as of the date of the person's initial application would not be sufficient because subsequent changes in eligibility requirements (other than the transfer of assets rule) could have rendered persons on medicaid ineligible for a period of time. Even if eligibility requirements were to be reconstructed for only one point in time, such as the date of the person's initial application, the effort and resources required are not, in my opinion, within the capabilities of the local departments of welfare. For example, local departments are not required to maintain old manuals and policies which have been superseded. Thus, local departments would have to consult with both the State Health Department and the State Department of Social Services to reconstruct the eligibility requirements for each person at each point in time that a bill was incurred. A possibility is that the Commonwealth could reconstruct eligibility manuals which set forth the eligibility requirements for any given point in time. Such an effort would involve a great expense in terms of time, material, money, and manpower. I cannot, however, provide an estimate of such an

expense at this time, but in my opinion, it would be a significant amount of money.

5) When the identified persons respond to the notice and when the eligibility case worker has determined what the eligibility requirements were, then the case worker must evaluate the person's application for eligibility. The costs associated with the evaluation of the application have been described in the affidavit of I. Guy Lusk executed this same day and attached to the State defendants' motion for a stay.

6) Following the eligibility determination, the state defendants must then determine what costs must be reimbursed, if any. The recipient would have to produce evidence of medical services received. Then, the state defendants would have to determine whether the service was covered under the state plan for medical assistance in effect on the date the service was rendered and whether the provider was an enrolled provider on the date in question in the medicaid program. Additionally, the state defendants would have to determine whether and to what extent the recipient had other insurance that made or should have made a payment toward the cost of the service.

7) For each type of claim, the history file must be pulled to verify that the provider was enrolled and the service covered. The service would have to be manually priced to reflect the Program's fee schedule in effect on the date of the claim for the service in question. Each claim must be edited, priced, rectified and forced through the claims payment system. I estimate the cost to be $5.00 per claim for just the preparation of claims processing.

8) If 1,000 people were to respond to the notice, it is anticipated that 500 people would have a claim for each of the 4 years in question. The average number of claims per person is 30 per year. Therefore: 500x30x$5=$375,000

cost to research, and prepare claims for payment for each year.

Thus, for 4 years, the cost will be $1,500,000 ($375,000 x 4). This $1,500,000 does not include the cost of the service itself.

9) Clearly, the court's order of July 22, 1982, involves the expenditure of considerable amounts of money. The expense can only be roughly estimated at this time, but most assuredly it is not inconsequential or minor. Furthermore, no funds have been appropriated for these purposes and these expenses would have to be deducted from current appropriations that are designated for current services and operations. Given the federal and the state budgetary situations, the Commonwealth would have to reduce the current expenditures of the Program by eliminating optional services and recipient groups.

ANN E. COOK

Sworn and subscribed before me this 29th day of July, 1982, in my jurisdiction.

PHYLLIS J. SISK
Notary Public

My commission expires: Oct. 28, 1983.

ORIGINAL

No. 83-1990

Supreme Court, U.S.
FILED
JUL 10 1984
ALEXANDER L. STEVAS
CLERK

In The
SUPREME COURT OF THE UNITED STATES
October Term, 1983

WILLIAM L. LUKHARD, Commissioner of the Virginia Department of Social Services; JAMES B. KENLEY, Commissioner of the Virginia Department of Health; and BRUCE U. KOZLOWSKI, Director of the Virginia Medical Assistance Program,

Petitioners

v.

EVELYN RANDALL, EMMA MATTHEWS, ARCHIE KYLE MORSE, MINNIE MILLER, WILLIAM E. SMITH, by his next friend, JUDY SMITH, POMPEY and RACHEL WINGO, and MAGGIE LAMB,

Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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July 1, 1984

34pp

QUESTIONS PRESENTED FOR REVIEW

1. Did the Court of Appeals for the Fourth Circuit err when it held that the Virginia Medicaid Program's "transfer-of-assets" eligibility rule in effect prior to July 1, 1981, was illegal because it violated 42 U.S.C. Section 1396a(a)(17)(B) and its implementing regulations?

2. Did the Court of Appeals for the Fourth Circuit err when it affirmed the District Court's order which, in addition to providing prospective injunctive relief, required the Virginia Medicaid Program to (a) identify class members, (b) notify them that the transfer rule had been declared invalid, and (c) apprise them of the existence of state administrative and judicial procedures by which they might obtain a determination of eligibility for past benefits?

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I. STATEMENT OF THE CASE

On April 24, 1980, Plaintiffs (now Respondents) filed this suit *in forma pauperis* on behalf of themselves and all other aged, blind, or disabled residents of Virginia who were similarly situated. They named as the Defendants (now Petitioners) the state officials who administer the Virginia Medicaid program.

At issue was the program's "transfer of assets" rule. This rule provided that an aged, blind, or disabled applicant for or recipient of Medicaid would be ineligible to receive benefits for one year if, within the preceding year, he had transferred or otherwise disposed of real or personal property to become or remain eligible for Medicaid or SSI benefits. The Respondents were persons who had, at one time or another, been disqualified from Medicaid on the basis of this.

Most of the Respondents were persons who, in their old age, were faced with a terrible choice. They had planned for years to bequeath their home or heirship property to their children, but for various reasons had not done so earlier. Had they done so, there would have been no Medicaid eligibility problem. Now they were told by Welfare Department officials that if they kept the property, they would be ineligible for their only source of income, SSI, because of "excess resources"; if they transferred the property to their children, they would lose their Medicaid benefits. Out of necessity they chose the latter course of action, and were declared ineligible for Medicaid for a year.

Suing under 42 U.S.C. Section 1983, Respondents sought a temporary restraining order preventing the Petitioners from disqualifying the named Respondents from Medicaid coverage; class certification; a declaratory judgment that the rule was illegal; temporary and permanent injunctive relief preventing the Petitioners from disqualifying class members from Medicaid coverage on the basis of the rule; notice to class members of

their right to reapply for assistance and possible reimbursement; and reasonable attorney's fees under 42 U.S.C. Section 1988.

At a TRO hearing on May 1, 1980, at the Petitioners' request, the Secretary of the United States Department of Health and Human Services was made a party defendant to the proceedings. Oral argument was scheduled for December 19, 1980, but on December 12 Congress enacted P. L. 96-611, the "Boren-Long Amendment". 42 U.S.C. Section 1396a(j). Section 5 of this new law established a new, nationwide transfer of assets rule for SSI applicants and, for the first time, authorized state Medicaid programs to apply similar rules to Medicaid applicants.

After discovery and extensive briefing of the legal issues concerning both the pre-1981 transfer rule and the new rule promulgated by the state pursuant to P.L. 96-611, the District Court issued its Opinion in April of 1982. Respondents accept Petitioners' summary of the District Court and Court of Appeals decisisions as set forth in their Petition, pp. 4-7. Respondents take strong exception, however, to Petitioners' assertion that their evidence regarding the cost of the relief ordered by the District Court was "uncontradicted." Petition, p. 6. See part III B of this Brief, infra.

II. SUMMARY OF ARGUMENT

On July 1, 1981, the federal "Boren-Long Amendment" took effect, authorizing states for the first time to use transfer-of-assets eligibility rules in their Medicaid programs. Prior to that date these rules were illegal for two reasons. Firstly, they were not authorized by the Social Security Act. Under principles announced by this Court in King v. Smith and other cases, states were therefore prohibited from enacting such rules if they violated federal eligibility provisions. Secondly, the effect of such rules was to presume that resources were

available to recipients to pay for medical care, when in fact such resources were not in any way "available." Therefore these rules violated the concept of availability contained in the Social Security Act.

Every federal court which has squarely considered the legality of these rules in "209(b)" states such as Virginia prior to 1981 has held them to be violative of the availability concept and therefore illegal. There is no meaningful "conflict" among the Circuits, because the Seventh Circuit in Synegael v. Ling was concerned only with the legality of Indiana's tranfer rule after July 1, 1981. It did not have argued to it, nor did it consider, the legality of the rule prior to that date. In addition, this Court's decision in Schweiker v. Gray Panthers requires that the availability regulations promulgated by the Secretary in 1972 be given significant deference, and that conflicting state provisions such as Virginia's transfer rule not be allowed to stand.

There is another reason why this issue is not an appropriate one for which to grant Certiorari. Given the length of time which has passed since these rules were in effect, and given the advent of the Boren-Long Amendment, it is highly unlikely that this issue will ever be before the Federal Courts again. It was a problem that required, and received, a legislative solution, and one that has lost its relevance and importance at this late date.

The notice relief ordered by the District Court and affirmed by the Court of Appeals comports with the requirements of the Eleventh Amendment, and is virtually identical to that approved by this Court in Quern v. Jordan. Petitioners' contention that the cost of relief in this case is not de minimis is without merit. Their cost figures are both vague and exaggerated, and in any event are less than 0.4% of the state Medicaid program's yearly budget. Petitioner's assertion that notice relief in this case would be "futile" seeks to introduce

issues into the case which are beyond the scope of appropriate Federal Court review in such matters.

III. ARGUMENT

A. THE LEGALITY OF VIRGINIA'S PRE-1981 TRANSFER RULE PRESENTS NO ISSUE WHICH, UNDER THE REQUIREMENTS OF RULE 17, JUSTIFIES GRANTING A WRIT OF CERTIORARI

1. Every Federal Court which has directly considered the issue has ruled that prior to July 1, 1981, Federal Law prohibited Medicaid programs in 209(b) states from having a transfer-of-assets eligibility provision.

The issue before this Court concerning the legality of the Virginia Medicaid Program's pre-1981 transfer-of-assets eligibility rule is simply this:

> Was the rule used by Virginia prior to July 1, 1981, illegal because it conflicted with the availability concept contained in the Social Security Act, 42 U.S.C. Section 1396a(a)(17)(B), and its implementing regulation, 45 C.F.R. Section 248.21(a)(2)(i) [1972]?

Every federal court which has directly confronted this issue in a 209(b)[1] state such as Virginia has reached the same conclusion: prior to the effective date of the Boren-Long Amendment[2] such rules were illegal, because they violated the concept of availability. Buckner v. Weber, 424 F. Supp. 366 (D. Conn, 1976), aff'd sub 434 U.S. 898 (1977); Udine v. Walsh, 440

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1. Pub. L. No. 92-602, Section 209(b), codified as 42 U.S.C. Section 1396a(f)

2. Pub. L. No. 96-611, codified as 42 U.S.C. Section 1396a(j), repealed in 1982 by Pub. L. 97-248, Section 132(b), and reenacted as 42 U.S.C. Section 1396p(c).

F. Supp. 1151 (E.D. Mo. 1977); Woodard v. St. Clair, CCH Medicare & Medicaid Guide Para. 30,804 (S.D. Miss. 1980); Dokos v. Miller, 517 F. Supp. 1039 (N.D. Ill. 1981); and Randall v. Lukhard, 536 F. Supp. 723 (W.D. Va. 1982) (Petition, App. p. 51-89), affd 709 F.2d 257 (4th Cir. 1983) (Petition, App. pp. 1-35), affd en banc, No. 82-1773, slip op (4th Cir. March 12, 1984) (Petition, App. pp. 36-49).

This unanimity of opinion is based upon three underlying principles. The first is the dominant role of the federal statutes in defining eligibility for Medicaid. The second is the nature of the availability concept itself. The third is the concept that if a Medicaid eligibility rule was illegal in 1972, its illegality was not affected by a state's opting in 1974 for 209(b) status. A brief discussion of these principles follows.

Since 1968, a fundamental principle of eligibility for both AFDC and Medicaid has been that a state cannot have an eligibility provision which excludes persons otherwise eligible under federal law unless such a provision is clearly authorized by the Social Security Act. This principle grew out of the case of King v. Smith, 392 U.S. 309 (1968).

In King, this Court was asked to interpret part of the Social Security Act governing eligibility for the AFDC program, 42 U.S.C. Section 602(a)(10). That provision required that state AFDC plans must provide "that aid to families with dependent children shall be furnished with reasonable promptness to all eligible individuals." This Court ruled that:

> "at least in the absence of Congressional authorization for the exclusion clearly evidenced from the Social Security Act or its legislative history, a state eligibility standard that excludes persons eligible for assistance under federal AFDC standards violates the Social Security Act and is therefore invalid under the Supremacy Clause." [Emphasis added] Townsend v. Swank, 404 U.S. 282, 284 (1971).

This principle applies, the Court added, even if the Secretary's regulations "seem to imply that States may to some extent vary eligibility requirements from federal standards." Id. The principle enunciated in King applies with equal force to state Medicaid programs, because the Medicaid eligibility provisions of the Social Security Act contain language identical to the AFDC language interpreted by this Court in King. 42 U.S.C. Section 1396a(a)(8).

In an effort to avoid the ramifications of King, Petitioners have cited New York State Department of Social Services v. Dublino, 413 U.S. 405 (1973), and Lavine v. Milne, 424 U.S. 577 (1976), for the proposition that "a state may promulgate additional eligibility criteria in social welfare programs." Petition, p. 9. As pointed out by the panel decision of the Fourth Circuit, however, neither of those cases deals with the situation in this case, where the state provision contradicts a federal eligibility provision. Randall v. Lukhard, 709 F.2d 257, 264 (4th Cir. 1983) (Petition, App. p. 33, f.n. 12).

In Dublino, this Court upheld a state rule requiring acceptance of employment as a condition to receiving AFDC. Noting that the state rule did not contradict any federal eligibility provision, this Court went on to say that:

> "so long as the state actions [as to the AFDC program] are not in violation of any specific provision of the Constitution or the Social Security Act, the Courts may not void them. . . if there is a [federal-state] conflict of substance as to eligibility provisions, the federal law must of course control. . ." [citations omitted] 413 U.S. at 423, n. 29.

In Lavine, this Court upheld a state rule prohibiting welfare payments to persons who quit their employment. In that case, as noted by the Fourth Circuit, "there was no federal provision involved at all, as the benefits were purely a matter of state law." Randall v. Lukhard, 709 F.2d at 264 (Petition, App. p. 33, f.n. 12).

The second principle underlying Medicaid transfer-of-assets litigation is that of availability. Since the very

beginning of the program, this concept has been one of the cornerstones of eligibility for Medicaid benefits.

The provisions of the Social Security Act dealing with eligibility for Medicaid were codified in 1965 at 42 U.S.C. Section 1396a *et seq.* Among other requirements, these provisions required each state Medicaid program to include "reasonable standards" which:

> "(B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and. . . as would not be disregarded. . . in determining his eligibility for such aid, assistance, or benefits. . ." 42 U.S.C. Section 1396a(a)(17)(B).

The legislative history for this provision shows that it was Congress's intent that the requirement of "availability" be given a broad interpretation and that its common sense meaning be given effect:

> "Another provision is included that requires States to take into account only such income and resources as (determined by the Secretary) are ***actually available*** to the applicant or recipient. . . in determining the eligibility for and the amount of the aid or assistance. . . Income and resources taken into account, furthermore, must be reasonably evaluated by the States. ***These provisions are designed so that States will not assume the availability of income which may not, in fact, be available or overevaluate income and resources which are available.***" [Emphasis added] S. Report No. 404, 89th Cong., 1st Sess. 74, 78 (1965); H. R. Rep. No. 213, 89th Cong. 1st Sess. 64, 67 (1965).

The Secretary implemented Section 1396a(a)(17)(B) in regulations which required that states consider "only such income and resources as are actually available." 45 C.F.R. Section 248.21(a)(2)(i) (1972), later recodified at 45 C.F.R. Section 248.3(b)(1)(1976) and 42 C.F.R. Section 448.3(b)(1).

This concept of availability for Section 1396a(a)(17)(B) was not developed in a statutory or case-law vacuum. Sections 402(a)(7) [APDC Program] and 1602(a)(14) [Aid to Aged, Blind, and Disabled Program] of the Social Security Act,

42 U.S.C. Sections 602(a)(7) and 1382(a)(14), for example, contained similar provisions. HEW's regulations implementing these provisions for both cash programs required that:

> "in establishing financial eligibility and the amount of the assistance payment . . . (c) only such net income as is actually available for current use on a regular basis will be considered, and only currently resources will be considered. . . ." 45 C.F.R. Section 233.20(a)(3)(ii)(c) [1973].

HEW's interpretation of these statutory provisions was approved by this Court. E.g., King v. Smith, 392 U.S. 309 (1968) [children could not be denied benefits solely on the basis of assumed income from men who neither supported them nor had a legal obligation to do so].[3] The Court noted in King that:

> "Regulations of HEW, which clearly comport with the statute, restrict the resources which are to be taken into account under Section 602 to those 'that are, in fact, available to an applicant or recipient for current use on a regular basis'. . . ." [Emphasis added] 392 U.S. at 319 n. 16.

Transfer of asset rules such as those used by the Virginia Medicaid program were classic examples of a rule that presumed the availability of resources to cover medical expenses when, in fact, those resources were no longer available to the applicant.[4] It was thus inevitable that these rules would be

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3. See also Van Lare v. Hurley, 421 U.S. 338 (1975) [nonpaying lodgers of AFDC families cannot be presumed to be helping with shelter costs]; Carleson v. Remillard, 406 U.S. 598 (1972) [children of absent members of the armed forces cannot be presumed to be receiving income]; Green v. Barnes, 485 F.2d 242 (10th Cir. 1973) [only owner's equity, not market value, can be counted].

4. There has never been any doubt that these rules are penalizing recipients for the value of these resources. When Congress enacted the Boren-Long Amendment, for example, the period of ineligibility was, in certain instances, tied directly to the value of the transferred resources. P.L. 96-611, Section 5, codified at 42 U.S.C. Section 1396a(j). See also Virginia Medicaid Manual, Section 301.1 D 3, 1st para. and Section d (Appendix, pp.1-2); P.L. 97-248, Section 132(b), codified at 42 U.S.C. Section 1396p(c).

contested on the grounds that they violated the availability concept. Where the rules were contested, the Federal Courts uniformly held that they must fall before the clear mandate of the availability provisions. For example, the Fourth Circuit stated in Randall v. Lukhard, 709 F.2d at 263-264 (Petition, App. p. 8):

> ". . . Virginia's former rule violated this plain language by including resources no longer 'actually available' to the applicant or recipient. It is apparent that resources that were previously irrevocably transferred to another person, regardless of the amount of compensation received, simply are no longer actually available."

See also Dokos v. Miller, 517 F. Supp. 1039, 1044 (N.D. Ill. 1981) ["the Federal provisions leave no room for recasting as 'actually available' any assets that the recipient or applicant has in fact relinquished."]

The third principle underlying these court decisions is a common-sense corollary to the availability concept: if a state Medicaid eligibility rule was illegal before the advent of the SSI program before the state opted for 209(b) status, it continued to be illegal after the change. It was not the intent of either the SSI program or 209(b) status to grandfather-in illegal eligibility provisions. This was the conclusion reached by all four Circuit Courts of Appeal that have dealt with the issue. Norman v. St. Clair, 610 F.2d 1228, 1235 (5th Cir. 1980), cert. denied, 453 U.S. 922(1981); Randall v. Lukhard, 709 F.2d 257, 264 (4th Cir. 1983) (Petition, App., p. 9); Winter v. Miller, 676 F.2d 276, 278 (7th Cir. 1982); Gray Panthers v. Administrator, 629 F.2d 180, 185 (D.C. Cir. 1980), rev'd on other grounds sub nom. Schweiker v. Gray Panthers, 453 U.S. 34 (1981).

These three principles have provided the courts with the basic framework within which Medicaid transfer-of-assets rules in 209(b) states must be judged. Using these three fundamental concepts, the Courts have been able to pierce the semantics and threadbare legislative history surrounding the

rules, and to focus on the intent of the federal eligibility provisions and the effect of the rules themselves. The uniform result has been the invalidation of these pre-1981 rules.

2. There Is No Meaningful Conflict Among The Circuits On This Issue.

The Petitioners, however, point to the case of Syposael v. Ling, 691 F.2d 1213 (7th Cir. 1982), reh. denied January 20, 1983, cert. denied, ____U.S.____, 103 S.Ct. 3092 (1983), and claim that "the circuits are in conflict as to the statutory issue of whether a 209(b) state could have a transfer-of-assets rule prior to 1981." Petition, p. 8. A review of that decision, however, makes it obvious that this issue was never presented to the Seventh Circuit.

The only issue which was considered by the appellate panel in that case was the legality of Indiana's transfer-of-assets rule after July 1, 1981, the effective date of the Boren-Long Amendment. To use the Court's own words:

> "The regulation thus has two parts: a five-year 'reach-back' provision, and a formula for determining the period of ineligibility if an improper transfer is found. Both parts are challenged in this appeal as contrary to the Boren-Long amendment, which is section 5(a) and (b) of Pub. L. 96-611, 94 Stat. 3567 (Dec. 28, 1980)." [Emphasis added] 691 F.2d at 121 .

The reason why the Syposael court never considered the legality of the transfer rule prior to 1981 is simple: that issue was not raised or contested by the parties. Again, in the Court's own words:

> "The parties agree that under the Indiana Medicaid plan in force on January 1, 1972, applicants who had transferred assets at any time within the preceding five years either for the purpose or with the effect of establishing eligibility for Medicaid were ineligible by virtue of Ind. Code Section 12-1-5-1(f), 12-1-7-14.9." Id.

Nowhere in the Court's opinion is there any mention of the concept of availability, of 42 U.S.C. Section 1396a(a)(17)(B), or of 45 C.F.R. Section 248.21(a)(2)(i). Nowhere does the Court focus on the legality of the rule prior to the passage of Boren-Long. Nowhere in any of the briefs submitted by the parties to the Court were these issues argued or even discussed. Because the issue was not raised by the parties, the Court merely took the legality of the rule before 1981 as a given, and began its analysis at that point.

In **Randall**, on the other hand, the issue of pre-1981 legality was the primary focus of both the District Court and the Circuit Court opinions. 536 F. Supp. at 729-31 (Petition, App. pp. 56-60); 709 F.2d at 263-66 (Petition, App. pp. 7-11). Because the Seventh Circuit "simply accepted the agreement of the parties," and because it "did not have argued to it, nor did it analyze," these crucial issues, the Fourth Circuit declined to follow **Synesael**. **Randall v. Lukhard**, 709 F.2d at 265-66 (Petition, App. p. 11).

3. Schweiker v. Gray Panthers and the Deference Due the Secretary's Regulations Require the Result Reached by the Court Below.

There are two other matters raised by the Petitioners for which some clarification is required. The first is the case of **Schweiker v. Gray Panthers**, 453 U.S. 34 (1981). In **Gray Panthers** this Court held that the Secretary's regulations interpreting 42 U.S.C. Section 1396a(a)(17) must be accorded great deference, even "legislative effect." 453 U.S. at 44. Both the District Court and the Court of Appeals in this case read **Gray Panthers** as requiring them to strike down Virginia's transfer rule as violative of the Secretary's 1972 availability regulation. **Randall v. Lukhard**, 536 F. Supp. at 730-31 (Petition, App. pp. 58-59), 709 F.2d at 264 (Petition, App. p. 8).

Petitioners, however, cite this case for two propositions: firstly, that this Court has held that the concept of availability under Section 1396a(a)(17) does not mean that resources need to be actually in hand, and, secondly, that courts should be particularly deferential to the federal secretary's interpretation of this provision of federal law. Petition, pp. 9-10.

To cite **Gray Panthers** in that fashion is to take the decision totally out of context. This Court made it clear in its opinion that availability has a special meaning when dealing with the eligibility of spouses, because the federal statute makes an exception to the requirement of availability in such instances.

> "It is clear beyond doubt that Congress was wary of imputing the income of others to a Medicaid applicant. Yet, as we noted above, Congress treated spouses differently from most other relatives by explicitly authorizing state plans to 'take into account the financial responsibility' of the spouse. 42 U.S.C. Section 1396a(a)(17)(D). Congress thus demonstrated that 'deeming' is not antithetical to the general statutory requirement that Medicaid eligibility be based solely on resources 'available' to the applicant. 'Available' resources are different from those **in hand**. We think that the requirement of availability refers to resources left to a **couple** after the spouse has deducted a sum on which to live." 453 U.S. at 47-48. [emphasis in the original]

Unlike deeming, which the federal Medicaid eligibility provisions clearly authorize as an exception to the availability concept, there is no such exception in the Medicaid statute authorizing transfer-of-assets rules. Therefore, the Fourth Circuit reasoned, the latter were not authorized by federal law, and were illegal before 1981. **Randall v. Lukhard**, 709 F.2d at 264 (Petition, App. p. 8).

As to the deference due the Secretary, this Court in **Gray Panthers** was clearly referring to the deference due the **regulations** promulgated by the Secretary to implement 42 U.S.C. Section 1396a(a)(17):

> ". . . the Secretary's definition of the term 'available' is 'entitled to more than mere deference or weight,' . . . [it] is entitled

> to 'legislative effect'. . . our task is the limited one of ensuring that the Secretary did not 'exceed his statutory authority' and that the regulation is not arbitrary or capricious." 453 U.S. 34, 44 (1981).

In Gray Panthers, this Court was asked to uphold a federal regulation promulgated by the Secretary; in this case, the Court is being asked to uphold a state regulation which directly contradicts a federal regulation promulgated by the Secretary. 45 C.F.R. Section 248.21(a)(2)(i) [1972].

Regarding the deference due the Secretary's support of Virginia's position in this case, there are two salient points. The Secretary has been a defendant in this case since 1980. Indeed, one of the first acts taken by the state defendants was to joint the Secretary as a co-defendant. The Secretary's interest in having Virginia's pre-1981 tranfser rule declared legal is substantial. A contrary holding means that for some fifteen years, the Department negligently allowed the state to disqualify hundreds of applicants on the basis of an illegal eligibility criterion.

In addition, the Secretary and the Department have significantly altered their position regarding transfer rules since the filing of this case. Only in August of 1980, some four months after this case was filed, did HHS determine that such rules were not, as it had previously held, "a form of financial eligibility criterion." Memorandum from Howard Newman, Administrator, HCFA, to Regional Administrators, August 13, 1980. Appendix, p. 3. When an agency reverses its position, the deference which it is otherwise due is severely undercut: "The weight of an administrative interpretation will depend, among other things, upon 'its consistency with earlier and later pronouncements' of an agency." Morton v. Ruiz, 415 U.S. 199, 237 (1974) [citations omitted].

The second matter which requires clarification regards Judge Russell's contention, in his dissent, that Congress implicitly sanctioned the Secretary's approval of transfer rules

such as that used by Virginia. Randall v. Lukhard, 709 F.2d at 273 (Petition, App. p. 25). An "implicit sanctioning" is a very dangerous and ambiguous concept, especially in an area as labyrinthine as Medicaid eligibility. Suffice it to say that when Senator Russell Long took to the floor of the Senate in support of his Boren-Long Amendment, which would for the first time allow the states to legally impose a transfer rule in determining eligibility for Medicaid, he candidly admitted that the rules were not then legal, and needed this change in the law to become legal.

> "In recent years a number of States have uncovered an abusive practice in which certain individuals transfer substantial assets to their families or to others in order to bring themselves down to the welfare eligibility level which will qualify them for payments under the supplemental security income (SSI) program and for full paid medical care under the Medicaid program. Unfortunately, the present law is so written as to make this subterfuge possible." [Emphasis added] 126 Cong. Rec. S. 16,505 (daily ed. Dec. 13, 1980).

See also the dissent of Judge Decker in Syposael v. Ling, 691 F.2d at 1213, 1217-20 (7th Cir. 1983).

In summary, then, the issue before this Court is not whether transfer-of-assets rules "should" have been allowed before 1981, or whether it would have been "better" if Congress had authorized them in the original Medicaid statutory framework. The fact is that such rules were not authorized by federal statute before passage of the Boren-Long Amendment. The doctrine of availability and this Court's holding in King v. Smith mean that, absent such authorization, 209(b) states such as Virginia were not free to adopt such rules. If such an omission prior to 1981 was, as characterized by the District Court, a "loophole", it was a legislative one, to be corrected by Congress. As the District Court succinctly stated:

> "In light of the Gray Panthers decision, however, the Court cannot disregard the Secretary's [availability] regulations and impose a judicial solution. Congress should provide a remedy, and indeed it has by enacting the Boren-Long Amendment." 536 F. Supp. at 731. (Petition, App. p. 59-60).

Both this Court and the Fourth Circuit have recognized that in the area of federal-state benefit programs, judicial sympathy for the stated aims of a state program must give way to federal eligibility standards:

> "While we sympathize with [the State's] desire to restrict its medical assistance benefits to those most in need, 'a State's interest in preserving the fiscal integrity of its welfare program may not be protected by the device of adopting eligibility requirements restricting the class of [individuals] made eligible by federal standards.' Townsend v. Swank, 404 U.S. 282, 291 (1971)." Fabula v. Buck, 598 F.2d 869, 873 (4th Cir. 1979); Randall v. Lukhard, 709 F.2d 257, 266, f.n. 15 (4th Cir. 1983) (Petition, App. p. 34).

One final factor weighs heavily against the Court's granting Certiorari in this case. Leaving aside for the moment the fact that all Federal Courts which have directly dealt with this issue have reached the same conclusion as the Fourth Circuit, and that only one Circuit Court of Appeals has squarely faced this issue, an additional reality remains. The issue of legality of pre-1981 transfer rules in 209(b) Medicaid states is, for all intents and purposes, a "dead issue." To the best of Respondents' knowledge, there are no other cases pending in any Federal Court dealing with this issue. Given the fact that it is now more than three years since the effective date of the Boren-Long Amendment and the state transfer rules promulgated pursuant to the Amendment, it is inconceivable that any new cases would arise at this point. Given this reality, and given the lack of any meaningful "conflict" among the circuits, the requirements of Rule 17 have not been met for this issue.

B. THE NOTICE RELIEF ORDERED COMPORTS WITH THE REQUIREMENTS OF THE ELEVENTH AMENDMENT AND QUERN V. JORDAN.

The relief ordered by the District Court in this case is set out in the Petition at pages 76-80 of the Appendix. To summarize the Court's order, it consisted of the following elements: (1) an injunction against state officials denying Medicaid to members of two of the Plaintiff (Respondent) classes solely on the basis of the transfer-of-assets rule; (2) the opportunity for certain named Plaintiffs (Respondents) to be reinstated, to seek reimbursement for covered expenses, and to have access to the administrative process if any dispute arose; (3) identification and reinstatement of class members to Medicaid if they are otherwise eligible; (4) notice to class members of eligibility for possible reimbursement of covered medical expenses; and (5) notice to health care facilities of the Court's decision.

The Court of Appeals made only one change in the District Court's order. It instructed the trial court to change the wording of the notice that would be sent to class members to clarify that Virginia's Department of Welfare was not "obligated" to make redeterminations of past eligibility, etc. 709 F.2d at 270 (Petition, App. p. 21). Rather, the notice should simply explain the court's ruling, advise that the case was at an end, and notify class members that they "will have to look to state administrative or judicial remedies, if any, for possible retroactive reimbursement." Id.

In response to the assertions made by the Petitioners regarding the propriety of the relief ordered below, Respondents would like to make five points.

Firstly, the role of an appellate court in this situation is simply to determine whether the District Court has abused its discretion under its equity jurisdiction. E.g., Swann v. Charlotte-Mecklenburg Board of Education, 402 U.S. 1, 15

(1971). The Ninth Circuit, for example, recently concluded, in precisely the same situation as this case (invalidation of a pre-Boren-Long transfer rule), that:

> "It was within the court's discretion, after considering the issues of cost and adminstrative burden raised by the state, to conclude that individual notice was the method best calculated to reach this class of aged, blind, and disabled persons." Beltran v. Myers, 701 F.2d 91, 94 (9th Cir. 1983), cert. denied sub nom. Bank v. Beltran, ___U.S.___, 103 S.Ct. 3115 (1983).

The relief proposed to the District Court by counsel for Respondents in this case, and adopted in large measure by the Court, was closely modeled after the relief ordered in Beltran. CCH Medicare and Medicaid Guide Para. 31,835 (C.D. Cal. 1982). There has been no abuse of discretion in either case.

Secondly, the relief ordered in this case is almost identical to the individual notice relief unanimously approved by this Court in Quern v. Jordan, 440 U.S. 332 (1979). In that case the Court described the issue as follows:

> "The issue now before us is whether that same federal court may, consistent with the Eleventh Amendment, order those state officials to send a mere explanatory notice to members of the plaintiff class advising them that there are state administrative procedures available by which they may receive a determination of whether they are entitled to past welfare benefits." 440 U.S. at 334.

All nine justices agreed that the answer to the question was "yes." Id.

This Court in Quern rejected the state defendants' arguments that the giving of the proposed notice would "lead inexorably to the payment of state funds for retroactive benefits" and therefore amount to a monetary award. 440 U.S. at 347. It explained that the chain of causation contained many missing links which could only be supplied by the state and the members of the class. 440 U.S. at 347-48. The Court noted that the notice was more properly viewed as ancillary to the prospective relief already ordered by the Court. 440 U.S. at 349. All of those considerations are present in this case to the

same extent as in Quern; both the District Court and the Court of Appeals were careful to tailor the notice to conform to these Eleventh Amendment requirements.

Thirdly, Petitioners argued that notice relief was "futile" because the class members would not be successful in seeking past benefits from the state administrative or judicial process. Petition, p. 14 f.n. 10. As explained by this Court in Quern, Petitioners' concerns in this regard are not appropriate concerns for the Federal Courts. 440 U.S. at 374-348. The eventual success of class mambers in obtaining relief is a matter which rests "entirely with the State, its agencies, courts, and legislature, not with the federal court." 440 U.S. at 348.

Fourthly, Petitioners' figures regarding the cost of complying with the District Court's order are unacceptably vague and greatly exaggerated. For example, in Ms. Cook's affidavit (Petition, App. pp. 117-120), the cost of mailing to class members would be "thousands of dollars," Petition, p. 11, and the expense of reconstructing eligibility criteria would be "significant." Petition, p. 12.

When Petitioners do come forth with concrete figures, they are inexplicably overstated. For example, in Ms. Cook's affidavit, she arrives at a cost of $375,000 per year, or $1,500,000 for four years, to prepare and research claims for payments. She bases this figure on her assumption that 1,000 people would respond to the notice, of whom 500 "would have a claim for each of the 4 years in question." Petition, App. p. 119. Since each person's disqualification period under the old transfer rule was only one year, Respondents are at a loss as to how Ms. Cook justifies her quadrupling of the total number of claims. The Petitioners' figure of $1,500,000 should thus actually be only $375,000.

In addition, the experience in Maryland suggests that the figure upon which Ms. Cook bases her other assumptions--that 1,000 people will respond to the notice--is far too high. In

Fabula v. Buck, 598 F.2d 869 (4th Cir. 1979), the Fourth Circuit invalidated Maryland's transfer rule. The state went to considerable lengths to carry out the individual notice relief ordered by the Court. According to the Maryland Attorney General's office, the Medicaid program there had estimated during the transfer-of-assets litigation that some 2,120 out of the 24,570 applications denied annually were due to the transfer rule. Letter from Assistant Attorney General David F. Chavkin to Counsel for Respondents, June 22, 1982. Appendix, pp. 4-5. A subsequent file review indicated that only sixty-three persons had been denied for such transfers during the three years in question. Id. And, despite widespread publicity of the Court's decision invalidating the rule, less than fifty hearings were ever requested by class members. Id. Respondents assert that the same numerical realities probably exist in this case, especially given the lapse of time--now over four years--since the filing of the case.

Lastly, even if this Court does accept the figures of the Petitioners as to the cost of complying with the order, they are still de minimis under any definition this Court might apply. Giving the Petitioners every conceivable benefit of the doubt, their figures appear to total less than $2,000,000. That figure comprises only 0.37%--less than four-tenths of a percent--of the Virginia Medicaid program's 1984-85 budget of $540,819,875.00. Acts of the 1984 Virginia General Assembly, Chapter 755, Item 395. In Milliken v. Bradley, 433 U.S. 267, 289 (1977), this Court held that Federal Courts are allowed to enjoin state officials to conform their conduct to requirements of federal law "notwithstanding a direct and substantial impact on the state treasury." The "ancillary cost" approved by the Court in

Milliken amounted to six million dollars. Hutto v. Finney, 437 U.S. 678, 690 f.n. 15 (1978).

If this Court finds it necessary at some juncture to clarify Quern or the concept of "de minimis cost," this case would seem a very poor vehicle for the task. The relief ordered was virtually identical to that in Quern, and the cost figures put forth by the Petitioners are vague, exaggerated, and at most a miniscule fraction of the program's budget, much less the state's budget. [5]

IV. CONCLUSION

Petitioners have raised no issues which, under Rule 17 of the Rules of this Court, would justify the grant of a Writ of Certiorari. Five District Courts and One Court of Appeal have squarely faced the issue of whether pre-1981 Medicaid transfer-of-assets rules in 209(b) states violated the availability concept; none have reached the conclusion advocated by the Petitioners. The result reached by these Courts was required by this Court's decisions in King v. Smith and Schweiker v. Gray Panthers. In addition, there is no real "conflict" among the Circuits because only the Fourth Circuit had argued to it and directly considered the issue. Given the advent of the Boren-Long Amendment and the reality that this issue will in all probability never again find its way into a Federal Court, it is no longer either important or relevant enough to justify this Court's time.

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5. In a case in which this Court recently denied Certiorari, the Fifth Circuit, citing Hutto v. Finney, 437 U.S. 678, 692 n. 18 (1978), ruled that before a cost of this sort becomes an Eleventh Amendment concern, it must be so great as to interfere not just with the budget of a single agency, but with the state's entire budgeting process. Silva v. Worrall, 621 F.2d 640, 652-53 (5th Cir. 1980), cert. denied, ____U.S.____, 101 S.Ct. 941 (1981).

In terms of the propriety of the relief granted in this case, it is virtually the same as that already approved by this Court in Quern v. Jordan. If the Court does feel it necessary at some point to clarify the concept of de minimis cost, surely a case with vague and exaggerated costs which nevertheless total only 0.4% of a state program's budget is not the proper vehicle.

For these reasons, Respondents request that this Court deny the Petition for a Writ of Certiorari.

Respectfully submitted,

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V. AFFIDAVIT OF FILING AND SERVICE

STATE OF VIRGINIA

COUNTY OF ALBEMARLE, to-wit:

HERBERT L. BESKIN, being first duly sworn, deposes and says:

1. I am counsel of record in this case for the Respondents, EVELYN RANDALL, et al., and a member 2 of the Bar of this Court.

2. On July 6, 1984, pursuant to Supreme Court Rule 28.2, I caused to be mailed, first class, postage prepaid, at the United States Post Office, Seminole Trail, Charlottesville, Virginia 22901, addressed to The Honorable Alexander L. Stevas, Clerk, Supreme Court of the United States, One First Street, N.E., Washington, D.C. 20543, the original and ten copies of (a) the attached Brief in Opposition to Petition for Writ of Certiorari, and (b) Motion for Leave to Proceed in Forma Pauperis, with accompanying affidavits.

3. On July 6, 1984, pursuant to Supreme Court Rule 28.5, I also caused to be mailed, first class, postage prepaid, at the same Post Office, a copy of (a) the attached Brief in Opposition for Writ of Ceriorari, and (b) Motion for Leave to Proceed in Forma Pauperis with accompanying affidavits, to each of the following persons:

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I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

Executed this 6 day of July, 1984, at Charlottesville, Virginia.

Herbert L. Beskin
Herbert L. Beskin

The foregoing instrument was subscribed and sworn to before me, a Notary Public in and for the State and County aforesaid, on this 6th day of July, 1984, by Herbert L. Beskin.

U. Grace Bert
Notary Public

My commission expires: August 23, 1987

Property Transfer - Any applicant for medicaid benefits is ineligible for a specified period of time if he/she improperly transfers or otherwise disposes of his/her legal or equitable interest in real or personal property without adequate compensation within two years prior to application for assistance. A recipient of medicaid benefits is ineligible for a specified period of time if he/she improperly transfers or otherwise disposes of his/her legal or equitable interest in real or personal property within two years of the discovery of that transfer. Such a transfer of property will result in the ineligibility of the assistance unit for two years from the date of transfer if the uncompensated value was $12,000 or less. The period of ineligibility will be increased two months for every $1,000 or part thereof of uncompensated value in excess of $12,000. The amount of the uncompensated value is the fair market value of the property, or the client's interest in the property, established for local tax purposes, less the amount of any compensation received for the property. Exceptions to this provision occur when:

a. A transfer of property was not made in an effort to become or remain eligible for medicaid or SSI. It will be the responsibility of the client to establish that such a transfer was not made in an effort to qualify for medicaid or SSI. The client must provide objective evidence that the transfer was exclusively for another purpose. A subjective statement of intent or ignorance of the property transfer provision is not sufficient. The client must provide evidence that other resources were available, at the time of transfer, to meet current and expected needs of that client, including cost of nursing home care.

b. Retention of the property would have no effect on eligibility unless the property is a residence of an individual in a nursing home for a temporary period.

c. When the transfer of property resulted in compensation to the client which approimxates the equity value of the property. This compensation can be in the form of money, goods or services. The value of goods and services must be reasonable for the community. The value of services provided by a member of the immediate family must be a reasonable rate established prior to receipt of the services.

d. When payment has been made on the cost of medical care which approximates the equity value of the property.

e. Disposition was the result of actions by another person, except a legal guardian or committee, who for any reason obtained the property without the client's full understanding of the action.

f. An improper transfer of property made by a caretaker-relative other than the parent will have no effect on the eligibility of the children.

EMORANDUM

HEALTH CARE FINANCING ADMINISTRATION
Office of the Administrator

Appendix . 3 -

: Regional Administrators DATE: AUG 13 1980 :

Howard Newman, Administrator
: Health Care Financing Administration

ECT: Transfer of Assets Prohibitions (memo of December 31, 1979-Region V)--
INFORMATION

In a memo to Robert O'Connor, Director, Bureau of Program Policy, the Medicaid Director in Region V asked, "Can a 209(b) State which has imposed a transfer of assets prohibition on January 1, 1972 to aged, blind and disabled medically needy applicants but not on AFDC medically needy applicants, continue to apply such restrictions?"

As you are no doubt aware, PIQ 77-14 dated 2/11/77, stated on page 2, "...transfe of property restrictions cannot be imposed on the medically needy unless comparat restrictions are imposed on the categorically needy, nor can such restrictions be imposed selectively on one group of medically needy and not on another."

The reasoning at the time was that transfer restrictions are a form of financial eligibility criterion. Since the Social Security Act requires comparability of financial eligibility criteria for all groups of the medically needy, we thought it followed that any transfer restrictions must be comparable for all groups of the medically needy.

We have subsequently reviewed this issue very carefully with the Office of General Counsel, however, and believe that this issue can be viewed differently and more flexibly. We believe a restriction on transfer of assets can and should more properly be viewed as a criterion which, although it goes to eligibility, is not a financial criterion within the meaning of the statute. Rather, the purpose of such a restriction seems to be to deter persons from transferring assets solely to obtain Medicaid eligibility. In this respect, it can be viewed as a means of controlling abuse of the program.

Therefore, we think PIQ 77-14 is no longer a valid statement of policy insofar as it indicates that these restrictions can not be imposed selectively on one group of the medically needy and not on another. Transfer restrictions <u>can</u> be imposed on one group of the medically needy and not on another, <u>so long as</u> there is <u>comparability between the medically needy group and its corresponding</u> categorically needy group.

We have had inquiries from several States, client advocates and regions on various aspects of our policies on property transfer restrictions. We are in the process of making a thorough reexamination of these policies.

EXHIBIT A

BEST AVAILABLE COPY

STEPHEN H. SACHS
ATTORNEY GENERAL

ELEANOR M. CAREY
PAUL F. STRAIN
DEPUTY ATTORNEYS GENERAL

Appendix 4

OFFICES OF

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
300 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201
AREA CODE 301-383-

June 22, 1982

Herbert L. Beskin
Charlottesville-Albemarle Legal Aid Society
420 3rd Street, N.E.
Charlottesville, Virginia 22901

Re: Fabula v. Buck

Dear Mr. Beskin:

Thank you for your letter of June 9, 1982 inquiring into the State of Maryland's implementation of the federal district court decision in the above-captioned case. I was not with the Office of the Attorney General during the period in question and therefore was not directly involved in the implementation of that decision. However, I have reviewed the Program's files for that period in order to respond to the questions raised in your letter.

Pursuant to interrogatories filed in the trial court, the local Departments of Social Services (who administer the Medicaid eligibility function in Maryland) were instructed to review all closed files to determine those persons who may have been affected by the invalid policy. That review was conducted of all cases back to December 19, 1976. That date was tied to the class definition certified by the trial judge.

I have enclosed copies of the instructions issued by the Medical Assistance Program of the Department of Health and Mental Hygiene (the single state agency) and the Income Maintenance Administration of the Department of Human Resources. That case file review was then updated to identify any persons who were denied after the initial answers to interrogatories.

Although the Medical Assistance Program had estimated during the pendency of the litigation that 2,120 out of the 24,570 applications denied annually were due to transfers of assets, the file review indicated that that estimate was grossly overstated. Only 63 persons were identified as having been denied for transfers during the three years in question. This figure does not include those persons who were denied for transfers of assets and were also denied on other grounds as well.

Those persons who were identified during the file review were individually notified of the Fabula decision and their right to file an appeal. No time limits were placed on their filing for an appeal. I have enclosed copies of the individual notices that were sent to class members.

In addition, the Program placed notices regarding the Fabula decision and the available remedies in more than 20 newspapers of general circulation in the State. I have enclosed a copy of that notice as well.

Although exact figures are not available, the total number of hearings requested pursuant to the Fabula decision probably numbered about 25 and certainly did not exceed 50. I previously sent you a copy of a representative Board of Review decision, the highest administrative tribunal in the Department of Health and Mental Hygiene.

I hope that this information adequately addresses the questions raised in your letter. The overall compliance statistics are rather sketchy and even Program staff directly involved in implementing the Fabula decision have little hard knowledge regarding the overall impact of the decision beyond that indicated herein.

Yours truly,

David F. Chavkin
Assistant Attorney General

DFC/kaa
enclosure

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